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ABSTRACT

This publication was written for therapists and their supervisors who may want to implement the adolescent community reinforcement approach intervention, which was one of the five interventions tested by the Center for Substance Abuse Treatment's (CSAT's) Cannabis Youth Treatment (CYT) Project. The CYT Project provided funding to support a study that tested the effectiveness of five interventions designed to reduce or eliminate marijuana use and associated problems in adolescents. Although information is still emerging about adolescent treatment effectiveness, there is considerable tension between efforts to develop short, cost-effective treatments and findings that 50 percent or more of adolescents relapse to marijuana or alcohol use within the first 3 months after discharge. There are, however, several promising options for improving treatment effectiveness that focus on motivational enhancement, relapse prevention, problem solving, coping strategies, case management, family support, family therapy, and working with adolescent'' to change their environments. This manual guides therapists and their supervisors in using the adolescent community reinforcement approach (ACRA) intervention with adolescents and their caregivers. The guide provides examples of exchanges between therapists and adolescents to illustrate how therapists help adolescents find or enhance reinforcers to abstinence, use community resources to support change, and develop family support. An appendix includes a detailed account of the CYT study. (Contains 51 references.) (GCP)

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The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users

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CYT

Cannabis Youth Treatment Series

Volume 4

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I. Introduction

Background

This publication was written for therapists and their supervisors who may want to implement the adolescent community reinforcement approach intervention, which was one of the five interventions tested by the Center for Substance Abuse Treatment's (CSAT's) Cannabis Youth Treatment (CYT) Project. The CYT Project provided funding to support a study that tested the effectiveness of five interventions designed to reduce or eliminate marijuana use and associated problems in adolescents.

The CYT study was important for several reasons. In 1996, marijuana use reached a 12-year high among adolescents ages 12 to 18 years (Institute for Social Research, 1997). Among eighth graders, 23 percent reported lifetime use, and 11 percent reported use in the past month. Among high school seniors, 45 percent reported lifetime use, and 22 percent reported use in the past month. Among 12- to 17-year-olds, marijuana has been the primary substance of abuse identified at treatment entry and mentioned in emergency room admission and autopsy reports (Office of Applied Studies, 1995, 1997).

Frequent marijuana use is associated with a syndrome characterized by apathy, decreased attention span, poor judgment, diminished capacity to carry out long-term plans, social withdrawal, and a preoccupation with acquiring marijuana (Cohen, 1980, 1981; Schwartz, 1987). It is also associated with co-occurring problems, including alcohol use, depression, anxiety, attention deficit/hyperactivity, conduct disorder, illegal activity, high-risk sexual activity, unwanted pregnancies, and difficulties at school and home (Donovan & Jessor, 1985; Farrell, Danish & Howard, 1992; Hawkins, Catalano & Miller, 1992; Jessor & Jessor, 1977; Kaminer, 1995; Musty & Kaback, 1995; Rob, Reynolds & Finlayson, 1990).

Seventy-nine percent of admissions for primary marijuana problems are treated in outpatient ambulatory settings, that is, about 69 percent in regular outpatient settings (1 to 9 hours per week) and 10 percent in intensive outpatient settings (9 to 15 hours per week). Although information is still emerging about adolescent treatment effectiveness, there is considerable tension between efforts to develop short, cost-effective treatments and findings that 50 percent or more of adolescents relapse to marijuana or alcohol use within the first 3 months after discharge (Brown & Vik, 1994; Brown, Vik & Creamer, 1989; Catalano et al., 1991; Kennedy & Minami, 1993).

There are, however, several promising options for improving treatment effectiveness that focus on motivational enhancement, relapse prevention, problem solving, coping strategies, case management, family support, family therapy, and working with adolescents' concerned others to change their environments (Azrin, Donohue, et al., 1994; Azrin, McMahon, et al., 1994; Brown et al., 1994; Graham et al., 1996; Kadden et al., 1989; Liddle et al., 1995).

Overview of the CYT Study

The CYT Study tested the relative effectiveness and cost-effectiveness of a variety of interventions targeted at reducing or eliminating marijuana use and its associated problems in adolescents and providing validated models of these interventions for the treatment field. The appendix provides a detailed review of the study.

The 3-year study began in October 1997. It was conducted in collaboration with staff from Chestnut Health Systems (CHS–MC) in Bloomington and Madison Counties, Illinois; the University of Connecticut Health Center (UCHC) in Farmington, Connecticut; Operation Parental Awareness and Responsibility (PAR), Inc., in St. Petersburg, Florida; and the Children's Hospital of Philadelphia (CHOP) in Pennsylvania. Members of the Executive Steering Committee of the study were Thomas Babor, Michael Dennis, Guy Diamond, Jean Donaldson, Susan H. Godley, and Frank Tims. During the study, adolescent participants were assigned to one of five treatment interventions.

1. **MET/CBT5.** This was a five-session treatment composed of two individual sessions of motivational enhancement therapy (MET) and three weekly group sessions of cognitive behavioral therapy (CBT). The MET sessions focused on factors that motivate adolescents who abuse substances to change; in the CBT sessions, adolescents learned skills to cope with problems and meet needs in ways that did not involve turning to marijuana or alcohol. This treatment was one of three interventions conducted at all four sites and was designed to be inexpensive and in line with what many parents and insurers seek as a basic intervention.

2. **MET/CBT5 + CBT7.** This treatment was composed of two sessions of MET and 10 weekly group sessions of CBT. It was designed to provide more of the same kind of treatment as MET/CBT5 to test for dosage effects. It was more in line with the type of treatment usually provided for adolescents.

3. **FSN.** The family support network (FSN) treatment included the MET/CBT5 + CBT7 group therapy plus engagement-type case management, family support groups, and aftercare. This treatment was designed to wrap several additional low-cost services around the MET/CBT5 + CBT7 group therapy and to address family issues and services in line with CSAT Treatment Improvement Protocol (TIP) Series recommendations.

4. **ACRA.** The adolescent community reinforcement approach to treatment was composed of 10 individual sessions with the adolescent, 2 individual sessions with one or more caregivers (e.g., a single parent or both parents), and 2 sessions with the adolescent and caregivers together. The intervention focused on rearranging environmental contingencies so that abstaining from marijuana was more rewarding than using it. ACRA therapists taught adolescents

how to find new reinforcers or enhance existing reinforcers for staying substance free, how to use existing community resources that were believed to support positive change, and how to develop a positive support system within the family.

5. **MDFT.** Multidimensional family therapy (MDFT) was a 12-week treatment, composed of 12 to 15 individual, family-focused sessions plus telephone and case management contacts. Depending on need or availability, therapists met with adolescents and family members individually or together. Sessions focused on roles, problem areas, and interactions among family members. This treatment used an integrated approach to family issues and focused on helping adolescents build more effective and age-appropriate interpersonal and conflict-resolution skills, while helping parents establish a more effective and supportive parenting style. Treatment also focused on building appropriate social supports with peers, schools, and other involved service providers.

All five therapies were based on treatment manuals to ensure that each intervention had a unique approach, was uniformly applied at every site implementing it, and could be replicated by others after the study had been completed. In the study, treatment manuals were paired with a strong quality assurance component that included reviews of actual taped sessions, which helped ensure compliance with the manuals.

These five treatments can be categorized in several different ways. First, they varied by mode; the first three were combinations of individual sessions and group approaches (i.e., groups of adolescents or groups of families), and the last two were approaches in which adolescents and family members were seen individually or with other family members. Second, the MET/CBT and ACRA interventions were based on behavioral treatment approaches, whereas the FSN and MDFT interventions were based on family treatment approaches. Third, they varied in resource intensity and cost.

In the study, approximately 150 adolescents were randomly assigned to 1 of 3 conditions at 4 sites. At two sites they were assigned to the brief MET/CBT5 or one of the other individual/group combinations (MET/CBT5 + CBT7 or FSN). At two sites, adolescents were assigned to the brief MET/CBT5 treatment or one of the individual approaches (ACRA or MDFT).

All conditions were replicated in two or more sites. Treatment was standardized by using a treatment manual and relying on support from expert workgroups. All adolescents were assessed at intake and at 3, 6, 9, and 12 months. To validate adolescents' self-reports, urine tests and collateral assessments were collected at intake and at 3 and 6 months. To minimize attrition, interviews that could not be completed in person at the 9-month interviews were completed by telephone.

The MET/CBT5 intervention consisted of five sessions provided over 5 to 8 weeks; the combined MET/CBT5 + CBT7, MDFT, and ACRA interventions lasted 12 to 14 weeks; and the FSN intervention lasted 12 weeks but had a

limited aftercare component that lasted another 12 weeks. Thus, the 3-month interview was usually the discharge interview, and the 6- and 9-month interviews occurred approximately 3 and 6 months after discharge. Data collection included use of the Global Appraisal of Individual Needs (GAIN) (Dennis, 1998), an onsite urine test for cannabis and cocaine, and a collateral assessment form with questions paralleling those of GAIN and addressing parenting issues. The full research design is described in Dennis et al. (under review).

The study began in late 1997. The recruitment and treatment phases of the study occurred over 18 months. Adolescents were followed up on a flow basis through spring 2000. Analyses were conducted on baseline characteristics of study participants, outcomes, and cost-effectiveness and are currently in the process of being published in peer-reviewed journals. Additional analyses will be conducted to learn more about the interventions and their interaction with different types of adolescents.

CYT followup data were based on more than 95 percent of the adolescents who participated in the study at 3-, 6-, 9-, and 12-month intervals after their intake date. These data revealed that the average number of days of use across conditions dropped from 36 days at intake to 23 days at 3 months and 21 days at 6 months. These results were largely sustained, with an average of 22 days at both 9 months and 12 months. An examination of individual response to the treatments showed that 70 percent of the participants reduced their marijuana use from intake to 6 months, including 29 percent who eliminated their use in months 4 through 6 and another 29 percent who cut their use by half or more. At 12 months, 69 percent were using less than at intake, including 35 percent who had eliminated their marijuana use in months 10 through 12 and 23 percent who cut their use by half or more.

Analyses of the effectiveness of the different interventions suggest that the outcomes for each intervention followed a similar pattern. Although some statistical differences existed at a given point in time, no one treatment was consistently better across time. This finding was a major advance over the mixed results from previous studies of existing models of adolescent treatment practice (with results that ranged from reductions in use among 20 percent of participants to increases in 18 percent) and the prevailing course of substance use (which increases sixfold between ages 12 and 21) (Dennis et al., in press).

The need for evidence-based treatment is great because the number of adolescents presenting for treatment of marijuana use disorders increased 135 percent from 1992 to 1998 and many treatment providers need to create adolescent services or expand their outpatient services. Because all of the CYT treatments worked, the Steering Committee recommended that service providers base their decisions about which ones to use on their resources and logistical constraints. For example, some agencies may prefer an approach that relies primarily on a group modality. Other providers may prefer an individualized approach because it fits with their agency's treatment philosophy or because their facility is located in a rural area.

Purpose, Development, and Organization of This Manual

This manual provides guidance on how to prepare for and conduct the ACRA intervention sessions with adolescents and caregivers. It also provides examples of exchanges between therapists and adolescents to illustrate what happens in actual ACRA sessions. Much of the adolescent community reinforcement approach is based on previous work using a community reinforcement approach (CRA) (Meyers & Smith, 1995). The CRA intervention was adapted for use with adolescents who abuse or are dependent on marijuana. One modification is the inclusion of urine screening for drugs, a procedure commonly used in adolescent substance abuse treatment. Other modifications of CRA used in this manual include (1) the addition of specific sessions for a caregiver only and for a caregiver and an adolescent together, (2) changes in the *Happiness Scale* and *Goals of Counseling* forms so that the categories are relevant to adolescents, (3) inclusion of urine-screening feedback procedures, (4) inclusion of dialog representative of interchanges between adolescents and therapists, and (5) requirements that snacks be provided routinely for the adolescents receiving the intervention. Some CRA procedures were eliminated (e.g., use of disulfiram, marital therapy) because they were not relevant for adolescents.

Modifications were pilot tested by therapists working with adolescents in tape-recorded sessions that were then made available to the principal authors of the manual for review. It is extremely difficult to capture realistic exchanges between therapists and adolescents in a manual because of the many extraneous variables that impact behavior during a treatment session. Nevertheless, the authors attempted to document as accurately as possible what it is like to conduct ACRA sessions. Therefore, the therapists and supervisor reviewed initial drafts of the manual and suggested changes to reflect actual practice.

This manual is organized into seven parts. Part I provides an introduction to ACRA. Part II provides an overview of the general theoretical underpinnings of the CRA model and an overview of the ACRA intervention. Part III provides detailed descriptions of 12 core procedures used in ACRA: 8 of the procedures apply to individual work with an adolescent, 2 procedures apply to individual work with caregivers, and 2 procedures apply to working with a caregiver and an adolescent together. Part IV provides descriptions of three optional procedures related to failure to attend, finding jobs, and anger management. Part V provides details on protocol monitoring procedures, including clinical supervision. Part VI contains the references. Part VII contains additional information on the CYT study.

II. Overview of the Treatment Model

Adaptation of Procedures From the Community Reinforcement Approach

Community reinforcement approach procedures were adapted in developing the adolescent community reinforcement approach procedures for youth who use and abuse marijuana, alcohol, and occasionally other substances. CRA procedures were adapted to meet the developmental needs of adolescents. It was also important that the procedures could be replicated in practice settings. CRA procedures are documented in treatment guides and manuals (Budney & Higgins, 1998; Meyers & Smith, 1995). These CRA procedures vary based on the research groups and target populations involved. For example, procedures for working with clients with cocaine addiction have included the use of vouchers as a contingency-management system in which drug abstinence is reinforced with points that have a monetary value that can be exchanged for desired prosocial items or activities (Budney and Higgins, 1998). When CRA procedures have been applied to alcohol abuse treatment, they have included the use of disulfiram or sobriety sampling (Meyers & Smith, 1997) and did not include the use of vouchers.

General Theoretical Assumptions of CRA and ACRA

Meyers and Smith (1995, p. 1) describe the theoretical underpinnings of CRA in this way:

> The Community Reinforcement Approach acknowledges the powerful role of environmental contingencies in encouraging or discouraging drug use, and thus attempts to rearrange these contingencies such that sober behavior is more rewarding than using behavior. CRA blends this operant model with a social systems approach. The overall philosophy is to use the community to reward nonusing behavior so that the client makes healthy lifestyle changes.

CRA procedures use operant techniques and skills training activities to teach individuals new ways of handling life's problems without drugs or alcohol. Traditionally, CRA is provided in an individual, context-specific approach that focuses on the interaction between individuals and those in their environments. CRA therapists teach an adolescent when and where to use the techniques, given the reality of each individual's social environment. This tailored approach is facilitated by conducting a functional analysis of the adolescent's behavior at the beginning of therapy. CRA therapists then teach individuals how to build on their reinforcers, how to use existing community resources that will support positive change, and how to develop a positive support system.

CRA is rooted in early work by Azrin and his colleagues (Azrin et al., 1982; Hunt & Azrin, 1973). More recently, CRA techniques have been adapted for use with:

- Concerned others to assist them in dealing with a loved one's drinking (Meyers, Dominquez & Smith, 1996; Meyers & Smith, 1997)
- Cocaine-addicted individuals (Higgins et al., 1991, 1993, 1994, 1995; Shaner et al., 1997)
- Homeless alcohol-dependent individuals (Smith, Meyers & Delaney, 1998)
- Adolescents in an assertive aftercare approach following a period of residential treatment (Godley, Godley & Dennis, in press)
- Adolescent substance abusers in an approach that integrated a community reinforcement plus vouchers (Henggler, unpublished).

In one of the few randomized field studies of adolescent substance abuse treatment, Azrin and his colleagues (1994) compared the effectiveness of a behavioral outpatient treatment program for substance-abusing adolescents with a supportive counseling program. Although not called a community reinforcement approach, the behavioral treatment program procedures appeared to have a common theoretical base. Like CRA, it incorporated parent attendance at all treatment sessions. When it was compared with the supportive counseling condition, the behavioral condition proved superior for reducing drug and alcohol use and improving school and work attendance (Azrin, Donohue et al., 1994; Azrin, McMahon et al., 1994).

A set of core procedures central to the CRA intervention includes:

- Using the functional analysis of substance use and the functional analysis of prosocial behavior
- Developing well-specified treatment goals and practical strategies to reach the goals, including training in using problem-solving skills, effective communication skills, and prosocial skills
- Emphasizing developing prosocial behaviors to replace activities related to substance use.

ACRA Goals

The goals of the individual ACRA sessions with adolescents are to:

- **Promote abstinence from marijuana, other drugs, and alcohol.** ACRA helps promote abstinence by working with adolescents to modify the conditions that promote substance use. To reach this goal, therapists use a procedure called the functional analysis of

substance use that helps an adolescent identify (1) the antecedents to marijuana, other drug, and alcohol use, (2) the actual marijuana- or other drug-using behavior, and (3) the positive and negative consequences of their use.

- **Promote positive social activity.** ACRA assumes that adolescents can be more successful at terminating substance use behavior if they learn how to increase their involvement in positive, reinforcing behaviors. A procedure called the functional analysis of prosocial behavior helps adolescents identify prosocial activities they enjoy or would enjoy and helps them see the benefits of being involved in these activities. Therapists then gradually encourage adolescents to spend more time in these activities.

- **Promote positive peer relationships.** This goal parallels the goal on positive social activity. Substance-abusing adolescents often center activities with friends on substance use. With this goal, ACRA therapists help adolescents identify attributes of "healthy" friendships and help them learn how to find and make new friends, how to deal with negativity, and how to ask for support.

- **Promote improved relationships with family.** Adolescence is a stressful time in the relationship between caregivers and the adolescent children in their care. This situation is probably even more stressful in families in which the adolescent is a substance abuser. Any distrust that caregivers have for the adolescent is reinforced by the adolescents' involvement in substance use. ACRA seeks to improve communication among family members as a way to enhance relationships.

The goals of the ACRA sessions with the caregivers are to:

- **Motivate their participation in the ACRA process.** It is possible that some caregivers may be reluctant to participate in an adolescent's treatment process. They may feel that the adolescent has "messed up" and the role of the treatment process is to "fix" him or her. The ACRA therapist's role is to help caregivers understand that they have an important role in helping their adolescent overcome a problem and to motivate the caregivers to participate in the therapy process.

- **Promote the adolescent's abstinence from marijuana, other drugs, and alcohol.** ACRA procedures teach family members behavioral skills aimed at discouraging an adolescent's drug use. The goal is to help caregivers understand how their behavior impacts the adolescent's substance use so that the caregivers will be motivated to change their own behavior to promote the adolescent's abstinence.

- **Provide information to the caregivers about effective parenting practices.** The information is based on the research of Catalano

(1998), Hops (1998), and Bry (1998) and includes measures to keep the adolescent from relapsing. These important parenting practices are:

- Be a role model by refraining from using drugs or alcohol in front of the adolescents in their care. This is the single most important parenting practice for caregivers.
- Increase positive communication with the adolescents in their care.
- Monitor adolescents' activities, including knowing where they are and whom they are with.
- Become involved in adolescents' life outside the home by encouraging and promoting prosocial activities.
- Teach and practice positive communication and problem-solving skills in the family. Improving communication and problem-solving skills within the family promotes a more positive relationship between adolescents and caregivers and helps create a familial environment that is more conducive to recovery.

The ACRA goals of working with the community are to:

- **Improve an adolescent's environment.** An adolescent may be interacting with several different systems, such as schools and the probation department. The therapist's role is to serve as the adolescent's advocate in these settings. There may be times when the therapist directly interacts with school personnel or helps teach the caregivers skills so that they can advocate at school for the adolescent in their care. If the adolescent is on probation, the therapist can work with him or her and the probation officer to encourage fulfillment of the probation requirements.
- **Teach the adolescent problem-solving skills and appropriate interactions through the use of roleplaying.**

About This Manual

This manual provides information about ACRA by presenting the sequence and suggested content of each session and how to implement each procedure. Procedures and sessions are not synonymous. The order of the procedures can be varied according to the needs of the adolescent and the caregiver.

Target Population

The manual describes an **outpatient** intervention that has been designed to be delivered in weekly sessions. The target population is adolescents

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appropriate for an outpatient or intensive outpatient level of care as defined by the American Society of Addiction Medicine's (1996) patient placement criteria. It is recommended that, before beginning this or any treatment program, adolescents first participate in a comprehensive biopsychosocial assessment to determine the appropriate level of care placement. The Cannabis Youth Treatment study used GAIN (Dennis, 1998). All the adolescents who participated in the testing of this intervention (1) were between the ages 12 and 18, (2) met criteria for current *Diagnostic and Statistical Manual of Mental Disorders* (DSM–IV) (American Psychiatric Association, 1994) diagnosis of cannabis abuse or dependence, and (3) had used marijuana in the last 90 days (or 90 days before being in a controlled environment). Adolescents were excluded from the study if the intake assessment revealed any of the following because they would be more appropriately served in a residential treatment program: (1) use of alcohol 45 or more days of the 90 days before intake (or before being in a controlled environment where relevant), (2) an acute medical condition that required immediate treatment or was likely to prohibit full participation in treatment and could not be managed in this level of care, (3) an acute psychological condition that required immediate treatment and/or was likely to prohibit full participation in treatment and could not be managed at this level of care, or (4) a history of violent behavior or severe conduct disorder.

ACRA was tested at two treatment sites. One was a large adolescent substance abuse treatment provider in Illinois that can provide all levels of care (i.e., early intervention, outpatient, intensive outpatient, and residential); the second was a major medical center affiliated with a university in Philadelphia. The following data are based on the 100 adolescents who participated in the ACRA intervention. The average age of the adolescents was 16 years, and 20 percent were female. In terms of race or ethnic composition, 44 percent of participants were black, 53 percent were white, 1 percent were Hispanic, and 2 percent were from other race or ethnic groups. Fifty-nine percent were from single-parent homes. In terms of education and employment, 86 percent reported being in school in the last 90 days, and 39 percent reported working in the last 90 days. Sixty-two percent reported current criminal justice involvement, and 66 percent reported some type of victimization.

Seventy-eight percent of the adolescents reported they were sexually active, with 47 percent reporting multiple sex partners in the last 90 days; almost a quarter said they had had unprotected sex. Sixty-eight percent reported weekly marijuana use, 43 percent reported symptoms of marijuana dependence, and 45 percent reported symptoms of marijuana abuse. Fifteen percent reported weekly alcohol use, 12 percent reported symptoms of alcohol dependence, and 30 percent reported symptoms of alcohol abuse. None of the adolescents reported weekly use or dependence symptoms of other drugs. Nine percent reported symptoms of abuse related to drugs other than alcohol or marijuana.

Overview of ACRA Sessions

Duration

The ACRA intervention described in this manual lasts for 3 months.

ACRA Therapist/Participants Ratio

During the CYT study, the ratio of therapists to adolescents was approximately 1 to 12. Therapists were involved in other activities that did not require a regular practice setting, so there was a higher ratio of participants to therapists in such a setting.

Contact Frequency

Individual face-to-face contact. Therapists provide approximately 10 individual sessions with the adolescent and 2 sessions with the adolescent and caregiver together over a 12- to 14-week period. Sessions usually last 60 minutes. The length of the session can vary according to the needs of the teen or the caregiver or at the discretion of the therapist. Other contacts by telephone or letter may be necessary between the in-person contacts to provide encouragement or motivation. If either the adolescent or the caregiver is unwilling to come to treatment, the therapist can offer the unused appointments to the one willing to come. For example, if the adolescent attends only five sessions and then refuses further treatment but the caregiver expresses interest in more than the two individual sessions allotted for a caregiver, the therapist can offer the caregiver additional sessions.

Caregiver contact. Therapists are expected to meet with caregivers for four face-to-face sessions (two with the caregiver alone and two with the caregiver and adolescent). If the adolescent lives with both parents, the therapist attempts to engage both parents in the caregiver sessions. If for some reason only one parent wants to or is able to attend the sessions, it is acceptable to work with the caregiver who is willing to attend. The first session (procedure 9) provides an opportunity for the therapist to give an overview of the treatment goals and develop rapport with the caregiver. During the second session (procedure 10), the therapist and caregiver work on learning and practicing communication skills. In the remaining two sessions, the therapist works with the caregiver and adolescent together to reinforce and practice caregiver–adolescent relationship skills (procedure 11). As noted above, if the adolescent drops out of treatment, it is possible to provide additional sessions to the caregiver.

Involvement of others in ACRA sessions. It is acceptable to invite other people to attend ACRA sessions when appropriate. Appropriate people to involve include a parent or other caregiver, a boyfriend or girlfriend, or other friends. These other people who play an important role in an adolescent's life could be involved during most of the procedures. For example, if an adolescent and his girlfriend usually attend parties together and he is willing to bring his girlfriend to a session, then it may be appropriate to work with both teens on the early warning system that is part of relapse

prevention (procedure 5). It might also be appropriate for an adolescent to bring a friend to a session to work on developing alternative prosocial behaviors (procedure 4). Whether or not to include someone else in a session depends on whether that person's involvement could help the adolescent attain his or her counseling goals and whether the adolescent wants to have that person attend a session.

Contact with community resources. Contact with community resources is based on individual need. For example, if an adolescent is in a detention facility, the ACRA therapist could go to that facility for a session. If the adolescent was referred by a school and appropriate releases are in place, the ACRA therapist could talk to school personnel about the adolescent's progress in treatment and advocate for him or her. The therapist might also provide monthly progress notes and discharge information to a criminal justice system case manager or a probation officer. Although these activities are acceptable in the intervention, therapists should discuss contacts with community resources with their clinical supervisors.

Referrals for Other Needed Services

Many adolescents requiring substance abuse treatment services have additional problems. It is assumed that ACRA is provided in a clinical environment that encourages the therapist to refer the adolescent and family members to other service providers for help when the adolescent has needs that cannot be addressed by ACRA. For example, if a therapist suspects that an adolescent has a mental health problem and might benefit from medication, the therapist would provide a referral to a family physician, a pediatrician, or a psychiatrist for a consultation. These referrals should be made, if possible, after consultation with a clinical supervisor. The therapist should also seek a signed release of information form from the participant and parent so he or she can provide background information about the adolescent, including that the youth is in treatment for a chemical-dependence problem, to the referred professional.

As treatment progresses with an adolescent, a more severe problem than originally thought may become apparent, and this problem may require a higher level of care (e.g., residential treatment). In this case, the appropriate referral should be made. There are often waiting lists for these services. If this is the case, the ACRA therapist should continue to provide treatment to the adolescent on an outpatient basis until there is an opening in the higher level treatment program.

Nature of the Intervention and Timing of Procedures

The suggested sequence of procedures, by session, follows. This sequence is only **suggested** because the therapist must always pay attention to maintaining a therapeutic alliance and to responding to the clinical needs of a treatment participant. For example, if the participant raises an issue that provides an opportunity to teach a procedure, the therapist should address the need presented by the participant rather than rigidly stay with a session plan. Or, if the therapist plans to conduct a functional analysis

of substance use but the adolescent mentions a significant problem, the therapist can introduce the problem-solving procedure. Later, the therapist can return to the functional analysis of substance use procedure.

Because ACRA attempts to use the reality of an adolescent's social environment, the therapist does not follow a didactic format with prescribed examples but uses real life opportunities for learning when they occur. Focusing on issues presented by the adolescent enhances engagement, a primary part of ACRA. Interaction between the therapist and the adolescent during the presentation and practice of procedures also enhances engagement and reinforces learning.

ACRA supervisors note that this flexible approach to using procedures can increase the difficulty of training therapists in ACRA procedures. It is easier to teach therapists how to deliver individual procedures than how to weave procedures into sessions as opportunities occur. Quality clinical supervision incorporating tape reviews is essential to the training process. Clinical supervision is described in part V.

Materials Needed

Because of the flexible nature of ACRA, the therapist should be prepared to use a variety of procedures and materials to meet the needs the adolescent presents during that session. The descriptions of procedures include the materials such as clipboards, pens, handouts, and copies of clinical forms (found at the end of each procedure section) appropriate for that procedure.

At the beginning of every session, the therapist offers the adolescent a snack and a drink. Suggestions for snacks include chips, granola bars, fruit bars, candy, cookies, and caffeine-free sodas or fruit juices. It is more practical to offer snacks packaged as one serving (not a whole bag of chips or a package of cookies). Offering the snacks serves as a primary reinforcer to help engage the adolescent.

Sequence and Content of Adolescent Sessions

Session 1: In the first session, the therapist meets with the adolescent and caregivers together for the first 15 minutes of the session. The goal is for the therapist to introduce himself or herself, build rapport, answer questions and provide information about the ACRA program, and make the family feel comfortable. The therapist discusses ACRA treatment success and philosophy and the focus of therapy sessions. He or she provides information about the length of treatment sessions, number and type of therapy sessions, disclosure of information policy, urine testing, and video- and audiotaping (if applicable). The therapist should praise family members for participating in treatment and try to make them feel comfortable by saying something like, "I'm really glad you came to treatment; I look forward to working with you!" The family is encouraged to ask questions during this initial session and at any time during treatment. The therapist should involve both the adolescent and caregivers by talking to or directing questions to everyone in the room.

Once the therapist reviews the necessary information with the caregiver, he or she explains that the rest of the session will be spent with the adolescent. The therapist's goal for the rest of the session is to develop rapport with the adolescent. The therapist can use the happiness scale (procedure 3) as a basis for conversation and to find out what is important to the adolescent. If time permits, the therapist and adolescent can begin work on the functional analysis of substance use (procedure 1).

Sessions 2–4: By the end of session 4, the therapist should have completed a functional analysis of substance use (procedure 1), a functional analysis of prosocial behavior (procedure 2), and at least one *Happiness Scale* form and a *Goals of Counseling* form (procedure 3). Encouragement of prosocial behaviors (procedure 4) also begins during the first four sessions. Other procedures may be used depending on the needs of the adolescent.

Sessions 5–10: These sessions follow a similar format but do not require that skills be taught in a standard sequence. Standard parts of each session include the following:

- Offering a food reward for session attendance
- Beginning the session with rapport-building interchanges
- Checking on homework completion
- Querying the adolescent about social activities or encouraging healthy social activities
- Checking on the adolescent's progress in completion of goals listed on the *Goals of Counseling* form
- Querying the adolescent about relationships with friends
- Querying the adolescent about relationships with family members
- Querying the adolescent about other problems
- Ending the session with a homework assignment related to the session content
- Reinforcing attendance at the present session and encouraging attendance in the future
- Scheduling the time and place for the next session.

Topics and skills that should be covered in these sessions are:

- Relapse prevention skills (procedure 5)
- Communication skills (procedure 6)
- Problem-solving skills (procedure 7)

- Urine testing (procedure 8)
- Caregiver–adolescent relationship skills (procedure 11).

Session 11: This session focuses on the skills presented in procedure 11. These skills may have been introduced earlier, but they may need to be reviewed.

Session 12: This last session includes the review of treatment goals and termination of services (procedure 12).

Sequence and Content of Caregiver Sessions

Sessions 1 and 2: The ACRA therapist meets with the caregiver without the adolescent present. The therapist:

- Begins the session with rapport-building exchanges
- Describes the goals of ACRA treatment
- Describes four behaviors that research has shown caregivers can do to help prevent the adolescent from relapsing
- Reinforces positive behaviors of parents or caregivers that support the adolescent and help prevent relapse
- Uses motivational procedures to encourage parental or caregiver participation
- Presents communication principles
- Reinforces attendance at the present session and encourages futures attendance
- Schedules the time and place for the next session.

Procedures 9 and 10 provide detailed descriptions for conducting the sessions with caregivers.

Sessions 3 and 4: The ACRA therapist meets with the caregiver and the adolescent together. The therapist:

- Reviews the goals of ACRA and the reason the caregiver and adolescent attend this session together
- Reinforces attendance at the session and encourages future attendance
- Helps the family members identify and talk about the things they like or appreciate about the other family members

- Reviews communication and problem-solving skills with the adolescent and family members

- Completes and reviews the *Relationship Happiness Scale* form (adolescent and caregiver versions)

- Practices relationship-building and communication techniques (e.g., how to solve problems, how to ask for things, how to receive things, how the caregiver can say no by offering alternatives, and how to remember to be nice).

Procedure 11 provides details about how to present these skills and activities. **Note regarding attendance problems:** If the adolescent and caregiver fail to attend, the therapist must attempt to reengage the adolescent and caregiver in treatment. Specific procedures for improving attendance are described in optional procedure 1.

Weekly Overview of Sessions

This section presents the information on session content by week.

Week 1:

- The therapist meets with the caregiver and adolescent for 15 minutes.

- Adolescent session: The therapist meets with the adolescent individually. Suggested procedures include rapport building (procedure 1), the functional analysis of substance use (procedure 1), the happiness scale (procedure 3), and problem solving (procedure 7).

- Caregiver session: The therapist meets with the caregiver individually for a 60-minute session. Suggested guidelines are outlined in procedure 9.

- The therapist contacts community resources if necessary.

Week 2:

- Adolescent session: The therapist meets with the adolescent following the session format (the *Functional Analysis of Substance Use* form is completed by the end of this session). The therapist introduces ways to increase prosocial recreation (procedure 4).

- The therapist contacts community services if necessary.

Weeks 3 to 5:

- Adolescent sessions: The therapist meets with the adolescent following the session formats.

- Caregiver session: The therapist meets with the caregiver for his or her second session following guidelines outlined in procedure 10.

- The therapist contacts community services if necessary.

Weeks 6 and 7:

- Adolescent sessions: The therapist meets with the adolescent following the session format.

- Adolescent and caregiver session: The therapist meets with the adolescent and the caregiver following the session format and guidelines in procedure 11.

- The therapist contacts community resources if necessary.

Weeks 8 to 10:

- Adolescent sessions: The therapist meets with the adolescent following the session formats.

- The therapist contacts community resources if necessary.

Week 11:

- Adolescent and caregiver session: The therapist meets with the adolescent and the caregiver following the session format and guidelines for procedure 11.

Week 12:

- Adolescent session: The therapist meets with the adolescent following the session format and procedure 12 guidelines for treatment closure.

Exhibit II–1 presents a weekly timeline of the ACRA sessions. This timeline should help therapists envision the structure and timing of the approach and can be used as a quick reference when scheduling sessions. It lists the procedures and the week each topic is recommended for introduction. It also provides information on the topic and the session participants.

Exhibit II–1:
Timeline of ACRA Treatment Sessions, Treatment Procedures, and Participants

Procedure Number	Timeframe	Topics Covered	Session Participants
1	Weeks 1 to 4	• Functional analysis of substance use	Adolescent
	Ongoing	• Rapport building	Caregiver and Adolescent
2	Weeks 2 to 4	• Functional analysis of prosocial behavior	Adolescent
3*	Weeks 1 to 4	• First happiness scale • First goal of counseling	Adolescent
	Any session	• Subsequent happiness scales • Subsequent goals of counseling	Adolescent
4*	Any session, but should begin in weeks 1 to 4	• Encouragement of prosocial behavior	Adolescent
5*	Any session	• Relapse prevention	Adolescent
6*	Any session	• Communication skills	Adolescent
7*	Any session	• Problem-solving skills	Adolescent
8	Weeks 5 to 10	• Urine testing	Adolescent
9	Week 1	• Caregiver's introduction to ACRA	Caregiver
10	Weeks 3 to 5	• Caregiver's communication skills training and review	Caregiver
11	Weeks 5 to 11	• Caregiver–adolescent relationship skills	Caregiver and Adolescent
12	Week 12	• Review of treatment goals and termination of services	Adolescent
Optional*	As needed	• Dealing with caregiver's or the adolescent's failure to attend • Find jobs • Anger management	Caregiver and/or Adolescent Adolescent Adolescent

*The therapist has the flexibility to introduce these procedures as needed based on situations presented in the therapeutic session.

Key Concepts of ACRA

Positive and enthusiastic approach. One of the key concepts of ACRA is that the therapist's approach to the adolescent and caregivers is positive

and enthusiastic. The therapist is always looking for opportunities to reinforce behaviors that can lead to less substance use. In contrast to some traditional substance abuse treatment approaches, ACRA therapists are rarely confrontational. This approach is consistent with the general CRA philosophy and is a logical approach to use with adolescents who are attending substance abuse treatment because of coercion (subtle or otherwise) from parents, school officials, or the criminal justice system. In addition, it is a developmentally appropriate approach with adolescents who may be oppositional or have a conduct disorder and whose resistance increases when confronted. If adolescents believe they have power in the counseling situation, they may be more willing to work with a therapist.

How ACRA therapists deal with uncooperative clients. Resistance and compliance issues are usually common and ongoing in a therapeutic relationship, especially when treating adolescents. Adolescents will usually resist change because their present behavior is meeting a need or providing a payoff they do not want to give up. They will often cling to existing behaviors until there is good reason to believe that a substitute behavior will be equally satisfying or reduce anxiety. Notice in the dialog example below that the therapist is not confrontational or argumentative. ACRA therapists never try to meet resistance head on and always try to avoid power struggles. The way a therapist responds to resistant behaviors is a critical component of ACRA. Resistance can be influenced or decreased by a therapist's behavior and style. It is difficult to provide step-by-step guidance on how a therapist approaches resistance because success in this endeavor is dependent on the total therapeutic approach. The approach should encompass behaviors that convey the most desirable of therapeutic qualities, including listening with empathy; having genuine concern; being open-minded, affirming, reflecting; praising and having expectations; and being accepting and rolling with the resistance. Compliance enhancement strategies begin with the first contact between the therapist and teenager and continue throughout the therapy episode.

Most of the examples of dialog provided in this manual use "compliant" adolescents to try to illustrate the procedures and their components. Each adolescent will pose his or her unique challenges. It is impossible to capture or demonstrate in one manual the wide variety of situations and problems that a therapist will face and the many possible ways to deal with these problems. Following is one example of how an ACRA therapist works with an adolescent who is resistant to coming to treatment; the therapist does not confront the adolescent about his drug use. Confrontation by the therapist may aggravate an adolescent's resistance. The therapist concentrates on developing a therapeutic alliance to deal more effectively with substance use later in therapy.

In this example, the therapist has already met with the adolescent and caregiver for introductions and has provided an overview of the ACRA treatment process. The caregiver has left the session, and the therapist is now meeting with the adolescent alone.

Therapist: *How are you doing with this, John?*

Adolescent: *Okay, I guess.*

Therapist: *Tell me why you think you are here and how I can help you.*

Adolescent: *My mom and parole officer think I need to be here.*

Therapist: *Do you think you need to be here?*

Adolescent: *No, not at all.*

Therapist: *That's okay and I can definitely understand that. Thanks for being so honest with me.* [The therapist tries to reinforce that the teen can communicate whatever he feels.] *Most people don't want to be here.* [Normalizes feelings.] *Tell me why your mom and parole officer think you need to be here.* [Asks open-ended questions to try to elicit more detail.]

Adolescent: *I guess because I am on probation, and my parole officer says I need to be.*

Therapist: *What are you on probation for?*

Adolescent: *I got busted with a joint at school. It wasn't even mine.*

Therapist: *That sucks. Have you ever been to treatment before?* [Doesn't focus on the drug use yet.]

Adolescent: *No, and I don't want to be now!*

Therapist: *I don't blame you. It can be a scary thing, not knowing what to expect and having to talk to a stranger. I want to tell you that you don't have to do anything that you don't want to do. I'm just here to help if I can. I really appreciate your taking the time and having the courage to come in here today.* [Reinforces attendance.] *I'm not here to tell you what to do or what not to do.* [Emphasizes personal choice, freedom, and control.]

Adolescent: *So you're not going to be riding me about drugs the whole time.*

Therapist: *No, not at all. Do people ride you about your drug use?* [Uses the client's own language, and asks indirectly whether he is using drugs.]

Adolescent: *Yes. It gets on my nerves.*

Therapist: *Who rides you?* [The therapist is still not confronting the adolescent about using. Instead, the therapist is searching for a source of motivation that can be used to engage the adolescent in the treatment process.]

Adolescent: *My parents, parole officer, teachers, principal, some friends—you name it.*

Therapist: *Sounds like that irritates you.*

Adolescent: *It does; you'd be irritated too!*

Therapist: *Do they ride you because they think you have a problem with drugs?*

Adolescent: *Now what do you think?*

Therapist: *I don't know. They may think you have a problem, or they may just not like the fact that you use drugs. Or do you? I know you said you got busted but that doesn't necessarily mean you are using.* [The therapist is not assuming use or accusing the client of using.]

Adolescent: *Yes, they think I have a problem.*

Therapist: *Do you think the drugs are a problem for you?*

Adolescent: *Not really.*

Therapist: *It sounds as if you aren't too concerned about your drug use but others in your life are; they are getting on your nerves about it; and that is irritating to you.* [The therapist is reflecting and summarizing.] *Because you are required to come here, let's make the most of our time together. Would you be willing to work together to try to get all these people off your case?* [Tries to create an alliance with the client. Attempts to get the client interested in treatment. The objective is to identify a complaint that the client is interested in changing to get him to participate in treatment.]

Adolescent: *So you're telling me that you're not going to make me quit?* [The client admits to using.]

Therapist: *I can't tell you what to do or what is best for you. Only you know that. You could go through treatment here and decide that it's worth it to you to keep using drugs as you have been. That will be up to you. So what do you say about trying to get all these people off your back?* [The therapist is rolling with resistance and not

initially focusing on the problem. The most important thing is to create an alliance in the beginning—giving the client a sense of freedom and providing choices rather than confronting him head on or arguing with him.]

Adolescent: *And how do you suppose we can do that?*

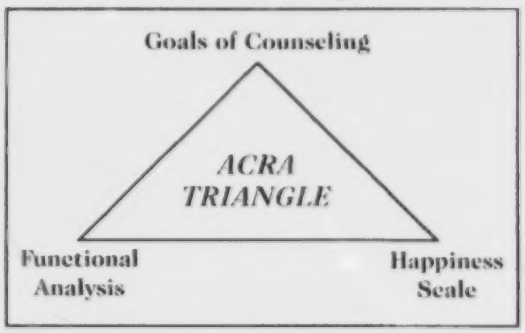
Therapist: *Well, that's what I would like to work on together. Because you know yourself and you know all those people riding you a lot better than I do.*

At the end of this dialog, the therapist is starting to build a relationship with the adolescent. At this point, the therapist can start working on the client's compliance through problem solving. The therapist will deal with the issue of using as it comes up. The goal is to address the adolescent's issues as he or she raises them. This can be accomplished at the same time the adolescent learns and practices the ACRA skills. The timing of implementing the procedures is a key factor in this model.

Other examples of an ACRA therapist handling a resistant client can be found in the sections that describe developing the ACRA treatment plan (procedure 3) and communication skills (procedure 6). These two examples illustrate how an ACRA therapist may attempt to handle resistance while interweaving the procedures in sessions.

The ACRA triangle. The core of ACRA is the relationship of three key ACRA procedures: the functional analysis, the happiness scale, and the goals of counseling. These three procedures are closely related and dependent on one another. The three key procedures join together to make up the ACRA triangle presented in exhibit II–2.

Exhibit II–2:
The ACRA Triangle



ACRA uses two types of functional analyses. One explores the antecedents and consequences of the adolescent's marijuana and alcohol use. The other explores positive, enjoyable activities that may serve as motivators for change.

The happiness scale rates the adolescent's feelings about several critical areas of life. It helps therapists and adolescents identify areas of life that adolescents feel happy about and areas in which they have problems. And, most important, it helps determine the direction of their discussion and helps them track the progress during treatment.

The goals of ACRA counseling are determined from the happiness scale and the functional analyses. Although these components are completed early in

treatment, all three components are viewed as works in progress. Therapists should revisit them often and ask adolescents to complete additional happiness scales approximately every 2 weeks.

Simple lay language. ACRA emphasizes the use of lay language. Therapists are encouraged to use language that is easily understood by adolescents and their families, hence the use of terms such as the happiness scale and the goals of counseling. ACRA therapists also are encouraged to engage in a normal conversational process when completing tasks such as the functional analysis of substance use behavior, prosocial behavior, and the goals of counseling.

Flexibility of ACRA. With a few exceptions, ACRA procedures are not tied to particular sessions. The approach is flexible, and therapists are trained to respond to cues provided by the adolescent, react to issues raised by the adolescent, and implement appropriate procedures in response (e.g., problem solving, examination of triggers).

Importance of roleplaying when learning new skills. Roleplaying is a critical component of the skills training used in ACRA, particularly for communication and problem-solving skills. It is very important that ACRA therapists become comfortable with encouraging and helping adolescents roleplay new skills in the protective environment of a session. Repeated roleplays increase the probability that new skills will be used outside the session.

Importance of homework. It is important for adolescents to complete homework between sessions. The homework consists of practicing the new skills and helps adolescents learn to use the new skills.

Requirements for an ACRA Therapist

Recommended Educational and Experiential Qualifications

An ACRA therapist should have a bachelor's degree in a counseling-related field and 5 years of experience or a master's degree in a counseling-related field. An ACRA therapist candidate should have a demonstrated orientation to a behavioral or cognitive behavioral approach. Prior experience with counseling adolescents or treating substance abuse is preferred.

Skills and Knowledge

Besides knowing how to deliver ACRA procedures, the therapist must have the following:

- Good basic counseling skills
- Knowledge and understanding of the developmental issues of adolescence
- Education or experience in interpreting clinical assessments.

The therapist needs to be an active listener and able to communicate empathy and genuineness during counseling situations with both the adolescent and parents. These skills promote engagement and help participants feel that they have some power in the therapeutic enterprise. These skills are not always readily discernible in an interview situation. Possible ways to assess whether a therapist has these skills are to see whether the individual has a history of good basic counseling skills, to review a sample therapy tape, or to obtain references from previous supervisors who reviewed his or her therapy tapes.

Adolescent developmental stages and accompanying behavior are extremely important for the therapist to know or learn during training. The therapist should have the ability to interpret clinical assessment information so that he or she can understand the adolescent's background and clinical needs.

Personal Qualities

Preferred qualities for such a therapist are a nonjudgmental attitude and a willingness to follow established procedures of the ACRA method. Positive and enthusiastic interpersonal skills are desired. Therapists who prefer analytic, solely didactic, or confrontational approaches probably are not good candidates.

Travel and Other Special Conditions or Requirements

Travel to an adolescent's home or other locations may be necessary if an adolescent has problems with transportation, does not attend sessions, or is in a controlled environment (e.g., a detention home). ACRA strongly emphasizes meeting the needs of the adolescent and caregivers through engagement.

Clinical Supervision Requirements

Weekly individual supervision and, if appropriate, group supervision by a clinical supervisor are recommended, as well as a weekly administrative case review meeting. A primary component of supervision is a review of taped treatment sessions by the clinical supervisor with feedback to the therapist on his or her ability to implement the ACRA protocol. As the supervisor reviews tapes, he or she also reviews the *ACRA Global Procedure Checklist* and the individual procedure checklists that are completed by therapists after each session. The *ACRA Global Procedure Checklist* provides an opportunity for therapists and supervisors to note what ACRA procedures were used, as well as which ones could have been used. The *ACRA Global Procedure Checklist* can be found in part V of this manual. The procedure checklists, which follow each procedure section, describe specific steps of each procedure. The therapist notes whether or not each step of the procedure is in progress, is completed, or has not been undertaken. If these checklists are used consistently after sessions or reviewed prior to sessions, they provide prompts to therapists to complete all steps in a given procedure. Clinical supervision and protocol monitoring are discussed in more detail in part V of this manual.

Procedure 1: Functional Analysis of Substance Use Behavior

Rationale

Functional analysis procedures provide basic information for therapists to use while implementing adolescent community reinforcement approach (ACRA) components during treatment (Meyers & Smith, 1995). They are based on structured interviews that examine the antecedents and consequences of a specific behavior. The specific behavior of interest can fall into one of two categories: a substance use behavior, such as the use of marijuana or the consumption of alcohol; or a prosocial behavior or activity that the adolescent enjoys, such as riding a bicycle or playing hockey. These two types of functional analysis procedures are used in ACRA. Procedure 1 focuses on the functional analysis of substance use. Procedure 2 describes the functional analysis of prosocial behaviors.

Purposes of the Procedure and Learning Objectives

The first purpose of this procedure is to uncover information about the adolescent's substance use behavior. One key purpose for conducting a functional analysis of substance use is to determine the teenager's "triggers" for marijuana or alcohol use. **Triggers** are thoughts, feelings, or behaviors that precede a using episode and are instrumental in leading the individual to use. By designating the chain of events that lead to use, the adolescent is made aware that the use of marijuana or alcohol does not "just happen." Rather, many small decisions lead up to the substance use behavior and are, therefore, within the adolescent's control.

A second key purpose for conducting a functional analysis of substance use is to clarify the positive and negative consequences of substance use that occur immediately and those that the adolescent thinks may occur in the long term. Once the teenager goes through this process, the goal is to help him or her realize that motivations exist to stop using and there are healthier ways to obtain some of the "pleasures" he or she gets from using. Information gleaned from this process is never used in a confrontational manner; the goal is to try to help the adolescent verbalize the consequences of substance use/abuse/dependence.

The learning objectives are to help the adolescent:

- Begin to uncover what is powerful enough to cause the adolescent to change his or her behavior
- Realize that motivations to stop using already exist
- Identify the **triggers** for substance use and their associated high-risk situations
- Identify and clarify substance use behavior

- Identify the **short-term positive consequences** of using
- Identify the **long-term negative consequences** of using.

Timing, Audience, and Delivery Method

Initially complete this procedure individually with an adolescent in sessions 1 and 2; revisit it in later sessions; and consider it a work in progress as the teenager's behaviors and needs change.

Materials

General materials include snacks (e.g., chips, crackers, granola bars, fruit bars), drinks (e.g., milk, fruit juice, caffeine-free soda), chairs, and (if applicable) a videocamera and videotapes or an audiotape recorder and audiotapes.

Procedure-specific materials include a clipboard, pens, and two *Functional Analysis of Substance Use Behavior* forms.

General Notes for the Therapist

At this early point in the relationship and basically throughout the treatment period, you need to establish and elicit positive expectations for change. Part of this entails persistently finding even small actions or statements that can be praised to enhance an adolescent's motivation for participating in the intervention. In addition, you should maintain a positive and enthusiastic tone of voice. Be sure to maintain a connection with the adolescent. For example, you might say something such as, "I can see I'm making you angry, so let's start over."

The steps outlined below explain how to conduct a functional analysis of substance use with the teenager at the start of therapy. However, this process is not a one-shot effort. It may be necessary to revisit the functional analysis of substance use process throughout therapy, as the adolescent's behaviors and needs change. The functional analysis of substance use, like the functional analysis of prosocial behavior and the treatment plan, is a work in progress. The procedures outlined below can be repeated as needed.

Forms are used to help conduct both the functional analysis of substance use and the functional analysis of prosocial behaviors. Use the forms only as guides. Although it is important to gather as much of the information as you can, do not feel as if you must use the exact wording on the forms. Rather, questions should be phrased in an open-ended manner as much as possible. If applicable, some of the information may be taken from the adolescent's biopsychosocial assessment that is completed before treatment begins.

Clarify assessment information before starting this procedure so that the teenager does not feel as if he or she is retelling the story. When talking with an adolescent, guide the conversation so that the form can be completed, but avoid making the form the focal point.

It is best to complete the *Functional Analysis of Substance Abuse Behavior* form in the presence of the adolescent, but it is not necessary to structure the session so that the focus is on answering questions. It is better to come back to the functional analysis of substance use at a later session than to risk alienating the adolescent by pushing him or her to provide information that may be difficult to recall.

The goal is for you and the adolescent to begin to determine what is powerful enough to help the adolescent change his or her behavior. For example, a powerful reinforcer can be to avoid going to jail. You can also begin to assess the teenager's internal or external motivations (e.g., Is he or she in treatment because of probation or parents/caregivers?). During this process, you can also learn about his or her using and nonusing friends. You might ask, "Do you have friends who don't smoke pot or get high? What do they do?" Another way to identify reinforcers is to ask whom the adolescent looks up to or who is the most positive influence in his or her life. For example, if a teenager talks about an older brother, you might ask, "What is your brother's name? Keith? So, Keith really doesn't want you to use and get in trouble again and have to go to jail." Later, in this or a subsequent session, you may want to refer to his or her desire to please Keith by staying away from substance use because the teenager has identified Keith as someone whose opinion is important to him or her.

If the opportunity presents itself, use praise throughout the functional analysis of substance use to promote engagement and to move the adolescent in the right direction. For example:

Adolescent: *I'm not getting high as often as I used to.*

Therapist: *That's excellent news, Johnny. How do you feel about that accomplishment?*

Adolescent: *Good, I guess.*

Therapist: *Yes, I feel good about it also. Congratulations! What an accomplishment!*

At the end of the first session (and every session), praise the adolescent for working with you. Communicate that the adolescent has provided useful information and has worked hard.

Procedural Steps

1. Use strategies for building rapport.

2. Provide an overview of ACRA.

3. Emphasize that this approach has been successful with others.

4. Explain the purpose of the functional analysis of substance use, introduce the *Functional Analysis of Substance Use Behavior* form, and gather information by:

   - Identifying internal and external use triggers
   - Identifying and further clarifying the substance use behavior
   - Identifying the short-term positive consequences of using
   - Identifying the long-term negative consequences of using.

5. Summarize functional analysis of substance use information, and praise the adolescent for participating in the session.

6. Complete the *ACRA Procedure 1 Checklist—Functional Analysis of Substance Use Behavior* immediately after the session.

Detailed Description

The remainder of this section contains a detailed overview for conducting a functional analysis of substance use with an adolescent. Procedural steps are in **bold type** and are followed by further directions and comments. Sample dialogs between a therapist and teenager are indicated in *italic type*.

1. Use strategies for building rapport.

The initial conversation with each teenager is critical in the rapport-building process. Most adolescents who drop out do so early in treatment. During the first two sessions, focus on the importance of engagement. Get the adolescent excited about working with you and about the treatment. Do not let filling out forms overshadow the rapport-building process.

Emphasize to the adolescent that you are glad to see him or her and you are glad that he or she came. Praise the youth for completing the assessment or for participation in previous treatment (e.g., if he or she were in residential treatment or intensive outpatient treatment before transferring to regular outpatient treatment). Ask, "Why did you decide to come to treatment?"

Set positive expectations, for example, "ACRA is a really good treatment and has worked for a lot of kids like you." You might say, "I'm glad we get to work together." Acknowledge the effort it took to come to treatment that day: "I'm glad you came. I want you to get something out of this" or "You can learn things that will be helpful for you." Note that it takes a lot of courage to come to treatment. Tell the teenager, "Anybody can get high; it takes real courage and character to quit!" Acknowledge some discomfort on your part and tell the youth, "I feel uncomfortable too at this point. We are in this together."

Explain that you will focus on what he or she wants to do in treatment. Emphasize the adolescent's independence. Give the adolescent the power to pick and choose the focus of sessions. Let the adolescent guide and move in the direction he or she desires. The goal is to give the teenager some sense

of control during the therapy session. Tell the adolescent, "I'm not going to ask you to do anything you don't want to do." You might also say, "How can I best help you?"

Be patient; do not push an adolescent when he or she is resistant. Ask open-ended questions as opposed to ones that require a short yes-or-no answer like "Do you like your Mom?" Rather, you might say, "Tell me a little bit about your relationship with your Mom." Ask open-ended questions about why he or she came to treatment, and let the teenager talk. Good examples of open-ended questions or conversation starters are the following:

- Tell me a little bit about yourself.
- Tell me what brought you here today.
- What do you think about being here?
- How do you hope to benefit from these sessions?
- Tell me more about what's going on in school.
- How would you describe how you are feeling today?
- What's going on today?

Many adolescents are not very verbal, so be patient as you wait for responses, and be willing to probe for additional information. Let adolescents know that you are there because you want to help. You might say, "We're going to teach you skills you need to know; then you won't need me any more. I'm just a guide. This isn't forever." Emphasize that the process is time limited, that is, "We have a limited time to work together, so we need to try to accomplish our business during the time allotted."

Try other ways to build rapport. For instance, you could try shooting baskets with a youth to build rapport. Feel free to provide food and a drink to a teenager. The snacks are not only potentially reinforcing; they also help keep energy levels up while the teenager is working on treatment issues.

Use the adolescent's language. For example, when you are talking about whom an adolescent from Philadelphia likes to associate with when using marijuana, you might say, "Who do you like to chill with when you are smoking weed?"

2. Provide an overview of ACRA.

In the first session, give adolescents an overview of ACRA in simple, lay language appropriate for them. Tell the adolescents how many sessions are involved both for themselves and their parents or caregivers during ACRA.

3. Emphasize that this approach has been successful with others.

Emphasize that the approach has worked for other people like the adolescent and can work for him or her as well.

4. Explain the purpose of the functional analysis of substance abuse, introduce the *Functional Analysis of Substance Use Behavior* form, and gather information.

Before you begin this procedure, review and become familiar with the teenager's assessment information. This will help you comment on and link any relevant information from the assessment as you complete the items on the *Functional Analysis of Substance Use Behavior* form. It also communicates to a teenager that you are familiar with and understand his or her situation.

Explain the purpose of the functional analysis of substance use, bringing any relevant assessment information into the conversation. Introduce the adolescent to the *Functional Analysis of Substance Use Behavior* form; hand the youth a copy so he or she can follow along during the process.

A functional analysis of substance use consists of three basic parts: identifying external and internal triggers to the behavior, documenting the behavior, and identifying the positive and negative consequences of the behavior. Point out the connections between the three steps of a functional analysis of substance use: triggers lead to behaviors that in turn lead to consequences (this is called the behavioral chain). During the introduction of the functional analysis of substance use, you will need to explain terms, such as triggers and consequences. Try to avoid using professional jargon that could interfere with the rapport-building process.

Information from the functional analysis of substance use is recorded on a form that can be placed in the clinical record for future reference. This form reflects the basic steps of the analysis noted above. Use the *Functional Analysis for Substance Use Behavior (Initial Assessment)* form. Blank and sample completed copies of the *Functional Analysis of Substance Use Behavior* form are included at the end of this section.

Deemphasize the act of filling in the form, because many adolescents are turned off by any activity that resembles school work. A good way to begin the procedure is to ask an adolescent to tell you about a typical situation in which he or she uses marijuana or alcohol. As the teenager recounts a typical episode, he or she will provide you with much of the information needed for the functional analysis of substance use. Later, you can ask additional questions to fill in any blanks.

Here is an example of how a therapist might introduce the functional analysis of substance use:

Therapist: *I'd like to learn more about how you view your drug use. I'd like you to help me understand more about your use. I have this form called a* Functional Analysis of Substance Use Behavior. *I'd like to fill it in. Could you help me? Here's a copy for you. We're going to talk about the types of things that led you to use marijuana in the first place. These might be things in your environment or things you feel inside yourself. Later, we will also talk about the positive and negative consequences of your marijuana use. I'd like for you to describe a typical time when you use marijuana or alcohol.*

Go through the four steps of completing the *Functional Analysis of Substance Use Behavior* form listed below.

Step 1: Identify internal and external use triggers and their associated high-risk situations.

Triggers are thoughts, feelings, or behaviors that precede a using episode and are instrumental in leading an individual to use. Reiterate that triggers lead to behaviors, which in turn lead to consequences. (In fact, you may want to write this on a board or clipboard before or after completing the functional analysis of substance use.) **External triggers** are associated with an individual's environment (whom they are with when they use, where they typically use, when they typically use), whereas **internal triggers** are associated with an individual's internal states (what adolescents think about, feel physically, feel emotionally before they use). Exhibit III–1 presents a sample of the section of the form about triggers.

Exhibit III–1: Triggers

External	Internal
1. Whom are you usually with when you use? *Friends, sister, sister's boyfriend*	1. What are you usually thinking about right before you use? *Getting high and hanging out with friends while everyone gets silly and laughs a lot*
2. Where do you usually use? *Friend's house (Sue)*	2. What are you usually feeling physically right before you use? *Don't know*
3. When do you usually use? *Nighttime*	3. What are you usually feeling emotionally right before you use? *Bored*

Explore with the adolescent the chain of events that set him or her up for using marijuana and/or alcohol. Ask the teenager to give you an example of a typical using episode. By addressing a typical, concrete situation, you can ask specific questions about the event, but the teenager's responses usually can be applied to many situations. If you need additional information about external triggers, the following questions can be used:

- "**Whom** are you usually with when you use?" (Particular friends, groups of friends, or relatives may serve as triggers to use.)
- "**Where** do you usually use?" (At home? At a friend's house? In the woods behind the school? At school dances? This question presents a great opportunity to point out high-risk situations.)
- "**When** do you usually use?" (Are there particular days or times of the day that the adolescent uses?)

As you are outlining triggers with a teenager, you may discover more than one typical using situation. For instance, an adolescent typically may smoke with a group of friends after school a few times per week, with friends every weekend at a teen hangout in the woods, and alone in the family's attic during the week. The teenager may also typically drink beer with friends at a party at least 1 weekend night. Each of these typical use situations should be treated separately, but functional analyses do not need to be completed for each situation.

Teenagers are likely to be able to use the procedure for identifying external triggers to identify other problems. If a problem situation is discussed, have the adolescent try to identify the triggers for the new situation without filling out another form. Start with the situation that is most common for a teenager. If the teenager identifies several similar incidents, you may want to group them together in one functional analysis of substance use. Often, one analysis for weekday events and one for weekend events suffice. Here is an example of an exchange about external triggers:

Therapist: *Okay, let's talk about triggers. Do you know what a trigger refers to?*

Adolescent: *Yes.*

Therapist: *Okay, please explain it to me.*

Adolescent: *Yeah, it's like a thing on a gun.*

Therapist: *What do you mean?*

Adolescent: *Well, you pull it and it goes off.*

Therapist: *Okay, a trigger on a gun is like a trigger for drug use. A trigger is something that leads to a behavior. For example, a trigger to getting high may be hanging out with friends who get high. Maybe the smell of marijuana leads to wanting to get high. Does this make sense?*

Adolescent: *Yes.*

Therapist: *What are some of your triggers? What triggers you to get high?*

Adolescent: *I don't know. I guess the people I'm around, 'cause everyone I know smokes weed.*

Therapist: *So everyone you know smokes weed?*

Adolescent: *Yeah, every day.*

Therapist: *Hmmm, every day. What time of the day do you usually get high?*

Adolescent: *Nighttime.*

Therapist: *I know you said everyone you know smokes weed. Whom do you smoke with?*

Adolescent: *My friends, my sister, my sister's boyfriend.*

Therapist: *Where do you usually go to get high?*

Adolescent: *Friend's house.*

Therapist: *Which friend's house?*

Adolescent: *Sue's.*

Next, ask the adolescent specific questions about his or her **internal triggers**. With a teenager who is having difficulty expressing his or her thoughts or feelings, you might try using visual imagery, for example, "Why don't you close your eyes and imagine where you usually use marijuana." Set up the scene where he or she tells you use occurs, and use imagery to help the teenager finish describing the whole episode. For example, if the adolescent typically uses in his or her bedroom, you could start by asking the adolescent to visualize the bedroom. Then go through what happens next. Another helpful approach with an adolescent (because of his or her emotional and cognitive developmental level) is to provide several examples of the type of information desired. The following are probes that can be used to identify internal triggers.

- "What are you usually **thinking** about right before you use?" Identifying the thinking process is critical because the teenager needs to see that, at some point, he or she makes a decision to use—using is not an automatic process. Thoughts also provide information on the adolescent's defense system and valuable insight into the feelings associated with using. For example, an adolescent might say, "I usually think about how much fun it would be to get high with my friends."

- "What are you usually **feeling physically** right before you use?" Bodily sensations can suggest different states of emotional arousal. For instance, a tight feeling in the chest, sweaty palms, and restlessness may suggest anxiety.

- "What are you usually **feeling emotionally** right before you use?" Identify how the teenager feels before using. For instance, it is important to know whether he or she typically uses out of an emotional reaction such as anger, frustration, or despair. Then you can spend more time on teaching adaptive behaviors in response to stress. Examine both positive and negative emotional states. What emotional statements trigger using behavior? For example, an adolescent who uses because of depression is making a statement about that depression when using. In addition, you

need to know whether an adolescent is using primarily because of a need to affiliate with peers.

Here is an example of a dialog about internal triggers:

Therapist: *Okay. Thanks for sharing that information on the external triggers. You're doing great. I'd like to ask you more about the internal triggers you may have.*

Adolescent: *Okay.*

Therapist: *Internal triggers are those that involve your thoughts and feelings about getting high. What are you usually thinking about right before you use?*

Adolescent: *I think about getting high and hanging out with friends.*

Therapist: *Okay. It sounds as if you like to spend time with friends. Tell me a little more about the getting high part.*

Adolescent: *Well, I look forward to us all being together and how we pass a blunt around and then all get silly and laugh and have fun.*

Therapist: *What are you feeling physically right before you use?*

Adolescent: *I don't know.* [It is acceptable not to get all the information initially; some adolescents will be better able to describe their feelings later in treatment.]

Therapist: *Okay. Do you know what you're feeling emotionally right before you use?*

Adolescent: *I feel bored—there's nothing to do.*

Therapist: *Oh, you feel bored? I wonder if we could talk about this more.*

Adolescent: *Okay.*

Therapist: *Does getting high help you to feel less bored?*

Adolescent: *Yes.*

Therapist: *Okay, you're doing great. This is really helping me get to know you better. Now I want to talk about what you use, how much, and typically how long.*

Step 2: Identify and further clarify the substance use behavior.

As you move from the triggers to the using behavior itself, you have another opportunity to impress on the adolescent the crucial connection between these triggers and using. Say, "Tell me about what goes on when you use." In addition, as you talk with the adolescent about his or her use, you will probably gather explicit details on patterns of use.

While focusing on the typical use situation identified above, gather explicit details on the teenager's use of the substance. The information collected should be as specific as possible.

- "**What** do you usually use?"
- "**How much** do you usually use?"
- "Over **how long** a period of time do you usually use?"

Here are more examples:

Therapist: *Okay, you're doing great. Now I'd like to ask a few questions to make sure I clearly understand your use pattern. Could you tell me what drugs you use most often.*

Adolescent: *Marijuana mostly, but sometimes I drink.*

Therapist: *Okay. Thanks for telling me. Let's talk about each separately starting with your marijuana use. When you get high, how much weed do you use and how do you use it (for example, in a joint or blunt)?*

Adolescent: *One or two blunts.*

Therapist: *Could you clarify: one or two?*

Adolescent: *Two.*

Therapist: *You said that you use at Sue's. Do you get high every day?*

Adolescent: *It's more like every other day.*

Therapist: *Okay. How much do you use and over what period of time?*

Adolescent: *We smoke two blunts in about 2 hours.*

Therapist: *Okay. Once again thanks for reviewing this with me; you are doing great. I appreciate your being open and honest with me. That's cool. Now I want to talk about positive and negative consequences of getting high.*

Exhibit III–2 presents a sample of the section of the functional analysis form about behavior.

Exhibit III–2: Behavior

Behavior
1. What do you usually use? *Marijuana* 2. How much do you usually use? *Two blunts, every other day* 3. Over how long a period of time do you usually use? *A couple of hours*

Step 3: Identify the short-term positive consequences of using.

Although drug abuse leads to long-term negative outcomes, adolescents certainly must be experiencing short-term positive outcomes to continue using. For instance, smoking marijuana may make adolescents feel more relaxed, may make them feel more affiliated with peers, or may help them temporarily forget their problems. It is important for you to acknowledge these positive benefits. It is true that these benefits are short lived, but they are enough to reinforce continued use.

The therapist's goal is to help an adolescent find the same reinforcers in a positive way. It often catches a teenager's attention when a therapist starts talking to him or her about the positive aspects of marijuana use. The approach is not judgmental, and, therefore, it can help engage the adolescent in treatment. You may want to briefly mention that later you will help the teenager find healthier ways to achieve some of these positive consequences.

While focusing on the typical-use situation, encourage the adolescent to talk about the positive aspects of using the substance. You can begin this procedure by saying, "I'm going to ask you something you may find surprising: What are the things you like about using pot?" Here are some additional ways to probe for short-term positive consequences of using:

- What do you like about using with [whom]?
- What do you like about using [where]?
- What do you like about using [when]?
- What are some of the pleasant **thoughts** you have while you are using?
- What are some of the pleasant **physical feelings** you have while you are using?

- What are some of the pleasant **emotional feelings** you have while you are using?

For example:

Therapist: *When I say consequence, what do you think I mean?*

Adolescent: *Well, something that happens afterward.*

Therapist: *Okay, yes. It's the result of a behavior, right?*

Adolescent: *Yeah.*

Therapist: *Okay. Well, usually there are both positive and negative consequences of smoking marijuana. Could you tell me more about what you think the positive consequences of getting high are? What are some pleasant thoughts you have while you are high?*

Adolescent: *I think about chilling and my future.*

Therapist: *Okay. What are some of the pleasant physical feelings you have while getting high?* [Therapist could also try to probe into what the adolescent is thinking about his or her future.]

Adolescent: *I feel relaxed.*

Therapist: *Okay. What are some of the pleasant emotional feelings you have while using?*

Adolescent: *I feel mellow.*

Therapist: *Tell me, what do you like about getting high with your friends, your sister, and her boyfriend?*

Adolescent: *It's cool to hang out with them—they're older than me.*

Therapist: *Oh, I see. What do you like about getting high at Sue's house?*

Adolescent: *Her mother is never around. So it's cool there.*

Therapist: *Is there anything you like about getting high at night?*

Adolescent: *It's cool to just hang out and chill.*

Step 4: Identify the long-term negative consequences of using.

Up to this point, the functional analysis of substance use has served to lay the groundwork for showing the adolescent the long-term negative

consequences that result from the using behavior just outlined. Now turn your attention specifically to the problems associated with the teenager's use of marijuana, other drugs or alcohol.

Focusing on the specific situation outlined at the beginning of the process, explore with the adolescent the problems that are associated with his or her using behavior. Probe for additional problems under each problem category. For instance, "Can you think of people you've had a problem with because of your marijuana use?" If the adolescent is having difficulty providing an example, you may want to offer examples, such as those below from the adolescent's assessment information. You might ask, "What are the negative results of your use regarding each of these?"

- Family members
- Friends
- Physical problems
- Emotional problems
- Legal consequences
- School problems
- Job problems
- Financial problems
- Other problems.

The goal is for the teenager to see the connection between substance use behavior and negative consequences. Although the adolescent may not always be willing to acknowledge the relationship between substance use and negative consequence, he or she may see the connection. An adolescent may mention a problem, and you may want to try to help him or her make the connection between substance use and this problem. For example, "Do you see that there is a connection between your legal problems and your use of marijuana?"

Some teenagers may completely resist verbalizing any negative consequences of their substance use. It is important for the ACRA therapist to accept the client's resistance and not to confront the adolescent. The *Functional Analysis of Substance Use Behavior* form and requests for specific information can be revisited at a later session after the relationship between the therapist and adolescent has had time to develop.

Here is an example of a dialog about negative consequences:

Therapist: *Okay. Now that I understand what the positive consequences of using are, I'd like to ask you about some of the negative or bad consequences. For example, how does getting high negatively affect your relationship with family members?*

Adolescent: *Well, my mother gets on my back, and my father takes privileges away.*

Therapist: *It sounds as if getting high causes problems between you and your parents.*

Adolescent: *Yeah, I guess so.*

Therapist: *How does getting high affect your friendships?*

Adolescent: *My girlfriend wants me to stop using.*

Therapist: *It sounds as if she really cares about you and wants you to stop using?*

Adolescent: *Yeah.*

Therapist: *How else does smoking affect you negatively? Tell me about any negative physical effects you have from using?*

Adolescent: *Like forgetting things?*

Therapist: *Yes, what else?*

Adolescent: *I often get dry mouth.*

Therapist: *Yes, dry mouth and memory problems are associated with marijuana use. Do you have any other negative physical feelings?*

Adolescent: *Sometimes I get tired.*

Therapist: *Emotionally or physically tired?*

Adolescent: *Both, like I want to just lie around the house.*

Therapist: *Like you don't want to do much?*

Adolescent: *Yeah. I don't want to do anything.*

Therapist: *Do you feel any negative consequences with other parts of your life like with your school or job, or legally?*

Adolescent: *Yeah. I got suspended from school for smoking outside the school.*

Therapist: *So it sounds as if getting high affects your life in school.*

Adolescent: *Yeah, I got suspended, and now I have to come here.*

Therapist: *Do you think getting high has affected you legally?*

Adolescent: *What do you mean by legally?*

Therapist: *I mean getting probation and going to court.*

Adolescent: *Okay, yeah. I'm on probation because I got caught smoking.*

Therapist: *Do you spend money on marijuana?*

Adolescent: *Yeah.*

Therapist: *How much do you spend a day?*

Adolescent: *I spend about $5 a day.*

Therapist: *Okay—so that's about five times four [days per week], which is $20 a week. Let's do the math. So $20 times four [weeks] is $80 a month . . . and $80 times 12 months is $960 a year.*

Adolescent: *Wow, that's a lot of money.*

Therapist: *It sure is. What do you think you might spend that money on instead of marijuana (or if you weren't getting high)?*

Adolescent: *Clothes, a car, give it to my girlfriend.*

Therapist: *Oh, okay. So you would have use for that money?*

Adolescent: [Laughs.] *Yeah.*

Therapist: *You would! Okay! Well, that's a little confusing to me, because it seems as if you are spending your money on things like weed. I wonder if you could explain this to me?*

Adolescent: *Well, I spend money to buy weed.*

Therapist: *I see. So, if you stopped smoking weed, would you have more money?*

Adolescent: *I guess so. Yeah.*

Therapist: *Wow. Thanks for helping me understand this. Let me see whether I've got this right. You could save money if you didn't buy weed, and if you didn't smoke weed, you wouldn't buy it. So, not smoking weed would actually save you money? Is that correct?*

Adolescent: *Yeah. I never thought about that.*

Therapist: *Yes, it's pretty cool. Isn't it?*

Adolescent: *Yeah.*

Therapist: *Are you interested in saving money?*

Adolescent: *I guess so.*

Therapist: *Okay. How do you think you could begin to save money?*

Adolescent: *I could smoke less often.*

Therapist: *Yes, you could. That's an excellent idea. I'd like to help you. Would that be okay?*

Adolescent: *Yeah.*

Therapist: *Good. I'm wondering whether we could talk more about the other things you'd spend your money on? I'd also like for you to track the amount of money you spend each time you get high. Would that be okay?*

Adolescent: *Yeah.*

Therapist: *Okay. Good. Let's talk more about how to do this when we meet next time, but could you start to keep a log of the amount of money you spend on weed?*

Adolescent: *Sure.*

Exhibit III–3 presents a sample section of the functional analysis form about consequences.

5. Summarize functional analysis of substance use information, and praise the adolescent for participating in the session.

After completing the functional analysis of substance use, summarize for the adolescent the information gathered through the process to ensure that the functional analysis of substance use is accurate. Do not forget to use positive reinforcement or to praise the teenager for his or her work and participation in the session.

This process provides the adolescent an opportunity to clarify use patterns and provides insight into the behavioral chain involved in his or her use. Most important, the information gained from the functional analysis of substance use provides the framework for the goals of counseling work that will follow. As illustrated in the earlier sample dialog, much information can be gathered that will be useful in later sessions. For example, you can see in the positive consequence column that several elements are reinforcing this adolescent's marijuana use. He likes to hang out with older kids and feels

Exhibit III–3: Consequences

Short-Term Positive Consequences	Long-Term Negative Consequences
1. What do you like about using with friends? [who] *They are older.*	1. What are the negative results of marijuana use? (behavior/activity in each of these areas): a. Family members *Mother gets on back; father takes away privileges.*
2. What do you like about using at Sue's house? [where] *Sue's mother isn't home.*	b. Friends *Girlfriend wants me to stop using.*
3. What do you like about using at night? [when] *It's cool to hang out and chill.*	c. Physical feelings *Forgetting things, tired, dry mouth*
4. What are some of the pleasant **thoughts** you have while you are using? *Chilling/my future*	d. Emotional feelings *Feel lazy*
5. What are some of the pleasant **physical feelings** you have while you are using? *Feel relaxed*	e. Legal situations *Probation, having to go to court*
6. What are some of the pleasant **emotional feelings** you have while you are using? *Feel mellow*	f. School situations *Suspended from school*
	g. Job situations *Not working*
	h. Financial situations *Spending $5 per day, $20 per week, $80 per month, $960 per year when using*
	i. Other situations

relaxed when using. It also appears that he has provided good information about his girlfriend that can be used later. It seems clear that he sees her as reinforcing his not using.

You should already be planning how to use this information in your work with the teenager to help him or her find ways of achieving desired feelings in healthier ways. In the example above, part of the process will include (at some point) asking the teenager why he likes to hang out with older kids. Is it because it helps boost his feelings of self-esteem or power? It would also be appropriate for the therapist to mention that she or he will be explaining later in treatment how the adolescent and therapist will work together to solve problems and to find healthier ways to relax or hang out with older kids (or find other ways to feel more powerful or boost the adolescent's confidence).

6. **Complete the *ACRA Procedure 1 Checklist—Functional Analysis of Substance Use Behavior* immediately after the session.**

A blank copy of this form is included at the end of this section.

Functional Analysis for Substance Use Behavior (Initial Assessment)

Triggers				
External	**Internal**	**Behavior**	**Short-Term Positive Consequences**	**Long-Term Negative Consequences**
1. Whom are you usually with when you use?	1. What are you usually thinking about right before you use?	1. What do you usually use?	1. What do you like about using with _____? (whom)	1. What are the negative results of _____ (behavior/activity) regarding each of these areas:
2. Where do you usually use?	2. What are you usually feeling physically right before you use?	2. How much do you usually use?	2. What do you like about using _____? (where)	a. Family members b. Friends c. Physical feelings
3. When do you usually use?	3. What are you usually feeling emotionally right before you use?	3. Over how long a period do you usually use?	3. What do you like about using _____? (when)	d. Emotional feelings e. Legal situations
			4. What are some of the pleasant thoughts you have while you are using?	f. School situations g. Job situations
			5. What are some of the pleasant physical feelings you have while you are using?	h. Financial situations i. Other situations
			6. What are some of the pleasant emotional feelings you have while you are using	

SAMPLE
Functional Analysis for Substance Use Behavior
(Initial Assessment)

Triggers				
External	**Internal**	**Behavior**	**Short-Term Positive Consequences**	**Long-Term Negative Consequences**
1. Whom are you usually with when you use? *Everyone I know smokes weed, friends, sister, sister's boyfriend*	1. What are you usually thinking about right before you use? *Getting high and hanging out with friends*	1. What do you usually use? *Marijuana*	1. What do you like about using with *Friends*? (whom) *They are older than I am.*	1. What are the negative results of *marijuana use* (behavior/activity) regarding each of these areas: a. Family members *Mom gets on my back. Dad takes away my privileges.*
2. Where do you usually use? *My friend's (Sue's) house*	2. What are you usually feeling physically right before you use? *I don't know.*	2. How much do you usually use? *One or two blunts every other day*	2. What do you like about using *at Sue's house*? (where) *It's cool there; her mom is never around.*	b. Friends *Problems with girlfriend. My girlfriend wants me to stop using.*
3. When do you usually use? *Nighttime*	3. What are you usually feeling emotionally right before you use? *Bored*	3. Over how long a period do you usually use? *Over a couple of hours*	3. What do you like about using *at night*? (when) *It's cool to just hang out and chill*	c. Physical feelings *Forget things, dry mouth, and tired* d. Emotional feelings *Feel lazy*
			4. What are some of the pleasant thoughts you have while you are using? *Chilling/my future*	e. Legal situations *On probation; having to go to court* f. School situations *Suspended from school*
			5. What are some of the pleasant physical feelings you have while you are using? *Feel relaxed*	g. Job situations *Not working* h. Financial situations *Spend all my money on weed*
			6. What are some of the pleasant emotional feelings you have while you are using? *Feel mellow*	i. Other situations

Date_____ Session #____ Adolescent ID____ Therapist Init._____

ACRA Procedure 1 Checklist—
Functional Analysis of Substance Use Behavior

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you establish a positive atmosphere for change?			
2. Did you build rapport with the adolescent by asking open-ended questions, using the adolescent's language, and praising the adolescent for working with you?			
3. If this is the first session, did you provide an overview of the ACRA intervention without using jargon?			
4. Did you emphasize that this approach has been successful with many people?			
5. Did you explain the purpose and process behind the functional analysis of substance use?			
6. Did you introduce the *Functional Analysis of Substance Use Behavior* form and go through the steps for completing it?			
7. Did you work with the adolescent to identify triggers for substance use and associated high-risk situations?			
8. Did you identify and further clarify the substance use behavior?			
9. Did you identify the short-term positive consequences of using and point out that these benefits are short lived?			
10. Did you identify the long-term negative consequences of using?			
11. Did you summarize the information provided during the functional analysis of substance use and help the adolescent see the behavioral chain involved in his or her use?			

Procedure 2: Functional Analysis of Prosocial Behaviors

Rationale

The functional analysis of prosocial behaviors is an important contribution to the substance abuse treatment field. Unlike many treatment approaches that focus solely on the negative consequences of substance use to motivate an adolescent to change, the ACRA intervention goes beyond negative consequences and uses positive, enjoyable activities as motivators to change (Azrin, Donohue, et al., 1994; Azrin, McMahon, et al., 1994; Meyers & Smith, 1995). However, before pleasurable activities can be used as motivators, they have to be behaviorally defined.

Begin this procedure by asking the adolescent to describe activities he or she enjoys that do not involve using alcohol or drugs. Then, as in the procedures for the functional analysis of substance use behavior, explore with the adolescent the triggers and consequences of these prosocial behaviors or activities that the adolescent enjoys.

Purposes of the Procedure and Learning Objectives

The purposes and learning objectives of this procedure are to help the adolescent:

- Identify pleasurable **nonusing (prosocial) behavior**
- Identify **positive triggers for prosocial behavior**
- Identify the short-term **negative consequences** of prosocial behavior
- Identify the long-term **positive consequences** of prosocial behavior
- Identify a real life activity related to **increasing prosocial activity** and commit to trying it.

Timing, Audience, and Delivery Method

This procedure should be completed within the first three treatment sessions and then revisited as needed during treatment. Conduct it individually with the adolescent.

Materials

General materials include snacks (e.g., chips, crackers, granola bars, fruit bars), drinks (e.g., milk, fruit juice, caffeine-free soda), chairs, and (if applicable) a videocamera and videotapes or an audiotape recorder and audiotapes.

Procedure-specific materials include a clipboard, pens, two *Functional Analysis of Prosocial Behavior* forms, activity lists, and the handouts *What Else Can I Do?* and *Activities That May Interest You*.

General Notes for the Therapist

Once again, maintain a positive and enthusiastic tone of voice to establish a positive atmosphere for change. Find even small things to praise to keep the adolescent's motivation high for participation in the intervention.

The functional analysis of prosocial behaviors, like the functional analysis of substance use behavior and the treatment plan, is a work in progress, not a one-shot effort. It may be necessary to revisit the functional analysis process throughout the treatment episode as the adolescent's behaviors and needs change. The procedures outlined below can be repeated as needed.

Procedural Steps

1. Explain the purpose of the functional analysis of prosocial behavior.

2. Introduce functional analysis, and gather information by:

    - Briefly reviewing the *Functional Analysis of Prosocial Behavior* form
    - Identifying and obtaining details on pleasurable nonusing behavior
    - Identifying positive external and internal triggers for prosocial behavior
    - Identifying the short-term negative consequences of the prosocial behavior
    - Identifying the long-term positive consequences of the prosocial behavior.

3. For accuracy, summarize the information discussed for the *Functional Analysis of Prosocial Behavior* form, and help the adolescent see the overall picture.

4. Assign homework.

5. Complete the *ACRA Procedure 2 Checklist—Functional Analysis of Prosocial Behaviors* immediately after the session.

Detailed Description

The remainder of this section contains a detailed overview for conducting a functional analysis of prosocial behaviors with an adolescent. Procedural steps are in **bold type** and are followed by further directions and comments. Sample dialogs between a therapist and an adolescent are indicated in *italic type*.

1. Explain the purpose of the functional analysis of prosocial behavior.

Explain to the adolescent that there are activities that he or she has enjoyed that did not involve alcohol or drugs. The purpose of this functional analysis is to discover what those activities are, to discover what the

triggers for them are, and to work on increasing opportunities to engage in these prosocial behaviors.

2. Introduce the functional analysis, and gather information.

Briefly review the *Functional Analysis of Prosocial Behavior* form. Copies of blank and completed *Functional Analysis of Prosocial Behavior* forms are included at the end of this section. Provide a copy of the form to the adolescent to allow him or her to follow along. You can record relevant information on the form either during or after the session, depending on what you think will work best with a particular adolescent.

Identify and obtain details of pleasurable nonusing behavior. The information gathered here goes into the middle column of the behavior chart.

- "**What** is the nonusing behavior/activity?"
- "**How often** do you usually [activity]?"
- "**How long** does [activity] last?"

As with the functional analysis for substance use, one form is completed for a specified activity. For instance, suppose a young woman says that she really likes dancing. The teenager attends dance class twice per week and goes dancing with friends on the weekend. The *Functional Analysis of Prosocial Behavior* form can be filled out by specifying her enjoyment of dance class. Then without necessarily filling out another form, you can see whether she can generalize from the first process and provide similar information for another pleasurable activity (e.g., dancing with friends on the weekend).

Following is an example of explaining the functional analysis of prosocial behavior process and identifying a pleasurable nonusing behavior:

Therapist: *Gina, now we're going to look at some of the positive activities in your life that don't involve using drugs or alcohol. One of the things we do while working together is try to help you increase the things in your life that are positive, the things that make you happy. Tell me a little bit about how you spend your spare time. I'd like to talk about interests you have other than getting high. What activities do you really enjoy?*

Adolescent: *I like pedal biking.*

Therapist: *Oh, what is pedal biking?*

Adolescent: *It's like riding a regular bike—not a dirt bike.*

Therapist: *Oh, I understand. I'd like to hear more about pedal biking.* [The therapist gives the adolescent the *Functional Analysis of Prosocial Behavior* form.] *This form is called a functional analysis; it's very similar to the form we filled out last time. I'd like you to follow along with me as we go through the questions. Does that sound okay with you?*

Adolescent: *Yeah.*

Therapist: *Okay, good. Let's get started.*

If the adolescent has difficulty identifying prosocial behaviors he or she enjoys, try the following:

Develop lists of activities that are available in the community. Examples of such lists, called *What Else Can I Do?* and *Activities That May Interest You*, are included at the end of this section. The first one simply lists activities available in the local area, and the second one provides lists of categories of fun things to do by the name of businesses and their addresses and phone numbers. These lists can be developed by working with adolescent groups wherever they are found—in community centers, schools, or treatment settings. When adolescents say there is nothing to do besides use drugs or they just have trouble generating different ideas, present the lists to help stimulate new thoughts. You can say, "This list may give you some ideas of things you would like to do that maybe you have not thought of doing."

Another approach is to ask, "What is something you really enjoyed doing in the past that did not involve alcohol or drugs?"; "What is something that you have always wanted to do?"; or "What is something you have seen someone else try that you thought was pretty cool?" Once an activity is selected, either from an activity list or from activities the adolescent is already involved in, you can begin working on the functional analysis.

Identify positive external and internal triggers for prosocial behavior. As you did with the functional analysis of substance use, ask about **external and internal triggers**. Start with specific questions about external triggers.

- "**Whom** are you usually with when you [activity]?"
- "**Where** do you usually [activity]?"
- "**When** do you usually [activity]?"

Then, move to internal triggers.

- "What are you usually **thinking** about right before you [activity]?"
- "What are you usually **feeling physically** right before you [activity]?"
- "What are you usually **feeling emotionally** right before you [activity]?"

It is important to help an adolescent make the distinction between a trigger that leads to drug use and a trigger that leads to prosocial behavior. Certain feelings or events may trigger both using behavior and prosocial behavior. For instance, feeling tired may prompt a person to smoke marijuana at one time and to go for a walk at another time. Help the adolescent discern what other factors influence him or her to use rather than to take a walk. Once this is determined, it may be helpful to shift the focus of the session to refusal skills or problem-solving skills, as appropriate.

Here is a sample exchange to determine triggers for the pedal biking prosocial behavior mentioned in the example above:

Therapist: *Who do you usually pedal bike with?*

Adolescent: *Friends.*

Therapist: *A group of friends or one friend.*

Adolescent: *Usually about five friends.*

Therapist: *Where do you usually pedal bike?*

Adolescent: *In North Philadelphia, on Broad Street.*

Therapist: *Okay. What time of the day do you usually pedal bike?*

Adolescent: *From about 4:30 till 8.*

Therapist: *Do you mean in the evening?*

Adolescent: *Yeah!*

Therapist: *Okay. Thanks for clarifying that. Tell me more about what you think about right before you go pedal biking.*

Adolescent: *About where to go and about riding my bike.*

Therapist: *Tell me more about that.*

Adolescent: *Well, I think about how I want to get out of my house, get with my friends, and ride around and see what's going on.*

Therapist: *Okay. Do you remember what you feel before you pedal bike? Do you feel any certain way physically?*

Adolescent: *No.*

Therapist: *Okay, how about emotionally?*

Adolescent: *Cool, I guess.*

Therapist: *Okay, great! How often do you pedal bike?*

Adolescent: *About two times a week.*

Therapist: *How long do you usually pedal bike?*

Adolescent: *A few hours.*

Therapist: *Okay. You're doing very well! It sounds as if you really enjoy pedal biking.*

Adolescent: *Yeah, it's cool.*

Identify the short-term negative consequences of the prosocial behavior. Sometimes enjoyable activities also have unpleasant aspects to them. Although the unpleasant aspects of a fun activity are usually immediate and brief, they can sometimes deter an adolescent from engaging in them at all. Examples of unpleasant aspects of fun are that the activity costs money or is a long distance away, that the adolescent does not have any friends to share the activity with, or that he or she has to get up early to do it or has difficulty fitting it into his or her day. Listen to any negative aspects of the intervention and determine how much of an obstacle or threat they are. How much of a deterrent are they? Are the negative consequences serious enough to keep an adolescent from engaging in the prosocial behavior? Problem-solving techniques may need to be used to help the adolescent figure out ways to solve problems that present barriers or result in negative consequences of engaging in the behavior.

Thus, it is important to acknowledge the negative aspects of the activity before moving on to the positive consequences. A negative consequence may be something as simple as lack of access to the reinforcer. Be sure to brainstorm ways to overcome these obstacles. If, for example, the adolescent would enjoy going to the library but does not have a library card, help the adolescent obtain a card. For example, ask, "How can we get a library card?" Never assume that the adolescent will make the initial contact independently. Encourage the adolescent to take steps toward obtaining desired reinforcers but be willing to locate and speak to a contact person in advance if there is an activity available. Be sure to review the adolescent's experience at such an event at the next session.

If the adolescent cannot think of any negative aspects to the enjoyable activity, do not push too hard because you want to keep the relationship positive.

- "What do you dislike about [activity] with [whom]?"
- "What do you dislike about [activity] [where]?"
- "What do you dislike about [activity] [when]?"

- "What are some of the unpleasant **thoughts** you have while you are [activity]?"
- "What are some of the unpleasant **physical feelings** you have while you are [activity]?"
- "What are some of the unpleasant **emotional feelings** you have while you are [activity]?"

The following is an exchange about negative consequences of the prosocial behavior:

Therapist: *Okay, now I'd like to ask you about the negative consequences of pedal biking. Is there anything that you dislike about pedal biking?*

Adolescent: *Yeah, when I catch a flat.*

Therapist: *Okay, how about biking in North Philadelphia? Is there anything you dislike about where you pedal bike?*

Adolescent: *Well, sometimes when I'm not in my own neighborhood, I don't know the people that are around.*

Therapist: *Okay, thanks for being honest with your answer; you're doing very well! Is there anything else you dislike about when you pedal bike?*

Adolescent: *No.*

Therapist: *Okay. When you are pedal biking, do you ever have unpleasant thoughts?*

Adolescent: *Yeah, that a car might hit me.*

Therapist: *So it makes you uncomfortable, maybe a little nervous about whether you can trust people you don't know or the drivers in cars?*

Adolescent: *Yeah, that's right.*

Therapist: *How about any unpleasant physical feelings you may have?*

Adolescent: *Yeah, like being thirsty, hungry, and sweaty!*

Therapist: *That happens. I understand. Do you have any unpleasant emotional feelings?*

Adolescent: *Yeah, I get scared that a car will hit me.*

Therapist: *That is scary; have you ever been hit?*

Adolescent: *No.*

Therapist: *Good! Okay, you did a great job with this part!*

Identify the long-term positive consequences of the prosocial behavior. Spend time probing this topic so that there is no question about what the adolescent finds reinforcing. You might say, "It looks as if you are into dancing (or whatever activity has been mentioned). What do you like about dancing?" Behaviors or activities that are reinforcing in many different areas of the adolescent's life, such as those listed below, are good candidates for behaviors that can compete with using drugs (Meyers & Smith, 1995, p. 33).

"What are the positive results of [activity] in each of these areas?"

- Family members
- Friends
- Physical feelings
- Emotional feelings
- Legal situations
- School situations
- Job situations
- Financial situations
- Other situations.

The following dialog is an example of probing to find the positive consequences of an activity:

Therapist: *Do you think there are positive consequences of pedal biking?*

Adolescent: *What do you mean?*

Therapist: *I mean that because you like to pedal bike, do you think that there are positive parts of pedal biking? For example, do you think that pedal biking has a positive effect on your relationship with your mother?*

Adolescent: *Yeah, she's happy because it keeps me off the corner.*

Therapist: *Okay, great! Do you think that it has affected your relationship with friends?*

Adolescent: *Yeah, I see more people when I pedal bike.*

Therapist: *Okay, good. Do you think that there are positive physical consequences of pedal biking?*

Adolescent: *Yeah, I can ride farther now.*

Therapist: *Oh, so pedal biking seems to have positive consequences physically. How about emotionally?*

Adolescent: *I feel as if I have more energy.*

Therapist: *Energy sounds more like a physical feeling. When I say emotional, I'm thinking about whether you feel happy, sad, bored, or something like that. What emotion do you think you feel?*

Adolescent: *Okay. Well, I'm happy because I do it with my friends.*

Therapist: *Good. How about legally? Has pedal biking had any positive consequences on your legal situation?*

Adolescent: *Yeah, it keeps me out of trouble.*

Therapist: *Yes, that is a positive consequence!*

Adolescent: [Laughs.]

Therapist: *Okay, has it had a positive effect on school?*

Adolescent: *No, I don't think so.*

Therapist: *Well, you mentioned that you felt as if you had more energy—what is the connection between that high energy and getting homework done?*

Adolescent: *Well, by the time I get home, I'm pretty tired so I don't always feel like doing my homework then.*

Therapist: *Oh, I see. How about with a job?*

Adolescent: *Well, I could ride my bike to work.*

Therapist: *That's right! Good thinking! How about financially? Would pedal biking have positive financial consequences?*

Adolescent: *Um, yeah. I could ride it to work and save money.*

3. For accuracy, summarize the information discussed for the *Functional Analysis of Prosocial Behavior* form, and help the adolescent see the overall picture.

After completing the *Functional Analysis of Prosocial Behavior* form, summarize the information gathered through the process so the adolescent can ensure that it is correct.

The information gained from the functional analysis of prosocial behavior provides additional material for the goals of counseling work that will follow

and for subsequent sessions. Work continually with the adolescent to increase the amount of time he or she is engaged in prosocial activities that do not involve substance use.

4. Assign homework.

Work **together** with the adolescent on a homework assignment, such as finding information about an activity or sampling a new activity identified during the session. Another homework option is to increase one or more pleasurable activities identified through the functional analysis of prosocial behavior. The homework assignment should specify the number of times or the amount of time the adolescent will engage in the activity. At the next session, you should discuss with the adolescent any obstacles he or she encountered while trying to complete the homework assignment.

If the adolescent appears unsure of his or her ability to perform these types of tasks, it would be good idea to make some of the initial steps during the session (e.g., call to find out when a facility is open or what the cost of admission is, or talk with a caregiver about helping with transportation).

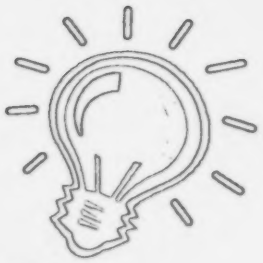
Do not forget to provide positive reinforcement or praise the adolescent for his or her work and participation in the session.

5. Complete the *ACRA Procedure 2 Checklist—Functional Analysis of Prosocial Behaviors* immediately after the session.

A blank copy of this form is included at the end of this section.

Handout

WHAT ELSE CAN I DO?



(Sample—Midwest)

skateboard
go out to eat
go to the movies
go shopping
rent a movie
walk around the mall
watch TV
go camping
lift weights
do aerobics
ride a motorcycle
play baseball
jog
go to Six Flags
ride a bike
join a youth group
play hockey
barbecue
go on a picnic
play volleyball
play golf
walk
listen to music
go to a sporting event
play football
skydive
play softball
play cards
attend a play
be in a play
travel
go camping
ride horseback
rollerblade
bowl
work at a craft
walk the dog
play a video game
use a computer
go to the park
ride a hot air balloon
attend a car show
play pool
box
go bungee jumping
take flying lessons
talk on the phone
go to a zoo
go to a museum
play a board game
make a pizza
go to a concert
learn to cook
go canoeing
write a letter
read a book
find a hobby
go skiing
visit grandparents
go to a library
mow the lawn
learn something new
draw
paint
write a poem
rearrange your room
get a job
help a neighbor
bathe a pet
test drive a car
hike
learn archery
play miniature golf
plant flowers
paint your room
go to a science center
shovel snow
start a journal
make a snowman
go snow sledding
go to an airshow
watch airplanes
visit caves
write a story
ride Metrolink
learn about computers
sing
play soccer
play a musical instrument
collect baseball cards
write a song
go snowboarding
get a makeover
do your nails
look at stars
play tennis
swing
pick flowers
put up new posters
help clean house
learn to take pictures
make a scrap book
organize your closet
make candles
try new foods
go dancing
try a new dance
go fishing
take an art class
go to batting cages
go to a carnival
swim
go to an amusement park
sunbathe
play Ping-Pong
make/decorate pottery
go to car races
go to driving ranges
scuba dive
ride go-carts
do gymnastics
make stained glass
try karate classes
try paintball
go rock climbing
get ice cream
go ice skating
play racquetball
take carriage/sled rides
go to a waterpark
take a nap
start a collection
get a different haircut
go boating
try jet skiing
exercise
run an errand for someone
go hunting
write rap music
take a class
play basketball
join a sports team
play laser tag
study for your driver's test
go to the YMCA
wash the car

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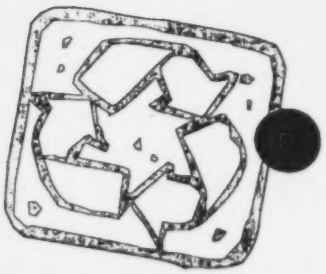
Handout

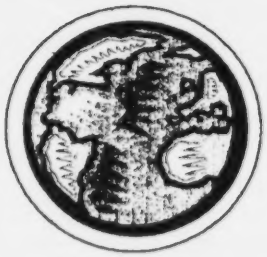


WHAT ELSE CAN I DO?

(Sample—Northeast Urban Area)

be on the student council
visit the Statue of Liberty
visit the Liberty Bell
go to Sesame Place
fix a car
surf the Internet
go food shopping for an elderly or sick person
shovel snow for an elderly or sick person
see a Philadelphia 76ers game
see a Phillies game
see an Eagles game
see a Flyers game
go to Dave & Busters
go to family game rooms
ride a dirt bike
attend summer school
attend the youth empowerment project
go jogging
buy stereo equipment
listen to a Walkman or Discman
learn to swing dance
learn to ballroom dance
deliver newspapers
work on an ice cream truck
babysit
have your hair treated or permed
braid your hair
help your family with food shopping
talk to neighbors
train for a triathalon
bake a cake
erase graffiti
play at PAL (police athletic league)
speak to a group about being drug free
watch the Learning Channel
watch the Discovery Channel
watch MTV or VH1
recite a rhyme
eat Chinese food
make grits
study for your driver's permit
go to Dorney Park
go to Great Adventure
go to the mountains
go to the beach
ride a bicycle
ride a unicycle
go to the circus
go to the ballet
see a Broadway show
go to New York City
go to Washington, D.C.
go to a gallery
fix a bike
fix a radio
play water polo
play basketball
play baseball
play tennis
play hopscotch
run track
go to a park
go whitewater rafting
join Neighborhood Watch
play Nintendo 64
go to Club Mcdonalds
go to club dances
learn to sew
learn to crochet
learn to knit
learn to read music
learn to play the piano
learn to play the guitar
take a horse and buggy ride
run up the art museum steps
hug someone
smile
laugh

SAMPLE
Handout



ACTIVITIES THAT MAY INTEREST YOU

Aircraft Flight Instruction

Metro-East Airport (Shafer Field)	2070 Triad Rd., St. Jacob	644–5411
Langa Air, Inc.	10 Terminal Dr., East Alton	314–895–8911

Amusement Places

Aladdin's Castle	133 St. Clair Sq., Fairview Hts.	632–1027
Family Fun Tyme	8 Gateway Dr., Collinsville	344–7747
Family Fun Tyme	1 Schiber Ct., Maryville	288–7747
G & B Amusement Co.	6930 W. Main, Belleville	397–7609
Games People Play	699 S. Bluff Rd., Collinsville	345–0885
Time Out	131 St. Clair Sq., Fairview Heights	632–1027
Time Passages Arcade	321 Broadway, Alton	465-1270

Amusement Parks

Six Flags	I–44 & Allenton Rd. Eureka, MO	314–938–4800

Antiques

Alton Landing Antiques	110 Alton St., Alton	462–0443
Antique Emporium	100 E. Warren, Bunker Hill	585–3929
Broadway Antiques	217 E. Broadway, Alton	465–0423
Belleville Antique Mall	208 E. Main, Belleville	234–6255
Richard's Antiques	2 N. Main, Wood River	254–5793
Maryville Antique Mall	2114 S. Center, Maryville	345–5533
MC Antiques and More	126 E. Chain of Rocks, Granite City	797–2581
Pywacket Antiques	215 E. Central, Benld	217–835–2970
Wagon Wheel Antiques	National and Academy, Pocahontas	669–2918

Aquariums (Public)

Mid-America Aquacenter	416 Hanley Industrial Ct. St. Louis, MO	314–647–9594

Aquariums

Aqua Pets	5733 Godfrey Rd., Godfrey	466–3474
Oceans Windows Pets	2755 E. Broadway, Alton	462–6353
The Swamp	2324 Nameoki Rd., Granite City	451–1852

Archery Ranges

Bullseye Archery	405 E. U.S. Hwy. 40, Troy	667–8616
Town Hall Archery Shop	Hwy. 15 and 59th St., Belleville	235–9881

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Functional Analysis of Prosocial Behavior

_____ (behavior/activity)

Triggers

External	Internal	Behavior	Short-Term Negative Consequences	Long-Term Positive Consequences
1. Whom are you usually with when you _____? (behavior/activity)	1. What are you usually thinking about right before you _____? (behavior/activity)	1. What is the nonusing behavior/activity? _____	1. What do you dislike about _____ (behavior/activity) with _____? (whom)	1. What are the positive results of _____ (behavior/activity) in each of these areas:
2. Where do you usually _____?	2. What are you usually feeling physically right before you _____?	2. How often do you usually _____?	2. What do you dislike about _____ (behavior/activity) _____? (where)	a. Family members b. Friends c. Physical feelings
3. When do you usually _____?	3. What are you usually feeling emotionally right before you _____?	3. How long does _____ usually last?	3. What do you dislike about _____ (behavior/activity) _____? (when)	d. Emotional feelings e. Legal situations
			4. What are some of the unpleasant thoughts you have while you are _____?	f. School situations g. Job situations
			5. What are some of the unpleasant physical feelings you have while you are _____?	h. Financial situations i. Other situations
			6. What are some of the unpleasant emotional feelings you have while you are _____?	

SAMPLE
Functional Analysis of Prosocial Behavior
Pedal Biking
(behavior/activity)

Triggers

External	Internal	Behavior	Short-Term Negative Consequences	Long-Term Positive Consequences
1. Whom are you usually with when you *pedal bike* ? (behavior/activity) *Usually about 5 of my friends*	1. What are you usually thinking about right before you *pedal bike* ? (behavior/activity) *Where to go*	1. What is the nonusing behavior/activity? *pedal biking*	1. What do you dislike about *pedal biking* (behavior/activity) with *friends* ? (whom) *When I get a flat*	1. What are the positive results of *pedal biking* (behavior/activity) in each of these areas:
2. Where do you usually *pedal bike* ? *North Philly*	2. What are you usually feeling physically right before you *pedal bike* ? *I don't feel any thing physically*	2. How often do you usually *pedal bike* ? *2 times per week*	2. What do you dislike about *pedal biking* (behavior/activity) *in North Philly* ? (where) *Sometimes I don't know the people around me.*	a. Family members *My mom is happy because it gets me off the corner.*
3. When do you usually *pedal bike*? *From 4:30 till 8 in the evening*	3. What are you usually feeling emotionally right before you *pedal bike* ? *Cool*	3. How long does *pedal biking* usually last? *A few hours*	3. What do you dislike about *pedal biking* (behavior/activity) *in the evening* ? (when) *I can't think of anything that I dislike about it.*	b. Friends *I see more people when biking.*
			4. What are some of the unpleasant thoughts you have while you are *pedal biking* ? *I think that I might get hit by a car.*	c. Physical feelings *I can ride longer distances.*
			5. What are some of the unpleasant physical feelings you have while you are *pedal biking*? *I get thirsty, hungry, and sweaty.*	d. Emotional feelings *I'm more energetic.*
			6. What are some of the unpleasant emotional feelings you have while you are *pedal biking*? *I get scared that a car might hit me.*	e. Legal situations *Keeps me out of trouble.*
				f. School situations *Keeps me out of trouble*
				g. Job situations *Could ride my bike to work if I got a job*
				h. Financial situations *I could save money by riding my bike to places.*
				i. Other situations

Date _____ Session # _____ Adolescent ID _____ Therapist Init._____

ACRA Procedure 2 Checklist—
Functional Analysis of Prosocial Behaviors

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you maintain a positive and enthusiastic tone of voice to establish a positive atmosphere for change?			
2. Did you explain the purpose of the *Functional Analysis of Prosocial Behavior* form and introduce the new analysis to the adolescent?			
3. Did you help the adolescent identify pleasurable nonusing behavior, encouraging the adolescent to include details?			
4. Did you help the adolescent identify positive triggers for prosocial behavior?			
5. Did you help the adolescent identify the short-term negative consequences of the prosocial behavior?			
6. Did you help the adolescent identify the long-term positive consequences of the prosocial behavior?			
7. Did you summarize the information in the *Functional Analysis of Prosocial Behavior* form to check accuracy and to help the adolescent see the overall picture?			
8. Did you help the adolescent come up with a homework assignment to sample a new activity identified through the functional analysis of prosocial behavior?			

Procedure 3: The Happiness Scale and the Goals of Counseling

Rationale

The happiness scale can be used frequently to assess how happy or satisfied an adolescent is in multiple life areas. These life areas include his or her use or nonuse of alcohol or drugs, relationships with friends and boyfriends or girlfriends, relationships with parents or caregivers, school, social activities, recreational activities, personal habits, legal issues, money management, emotional well-being, communication, and general happiness. When the *Happiness Scale* form is completed early in treatment, it shows areas of an adolescent's life most in need of attention. Although the happiness scale can be used as a barometer of progress at any time, one of its important uses is to gather information to help complete the *Goals of Counseling* form.

The *Goals of Counseling* form is the ACRA version of a treatment plan. It allows therapists and adolescents to define treatment goals and activities related to the same domains that are assessed with the happiness scale.

Purpose of the Procedure and Learning Objectives

The purpose of this procedure is to help the adolescent understand how the **happiness scale** and **goals of counseling** assist with development of a treatment plan.

The learning objectives are to:

- Devise a step-by-step intervention with the adolescent to reach his or her treatment goals
- Assist the adolescent in selecting and committing to a **homework** assignment based on the goals of counseling.

Timing, Audience, and Delivery Method

Both the happiness scale and the goals of counseling procedures are conducted with the adolescent individually. A happiness scale should be completed in sessions 1 and 2, prior to beginning work on the goals of counseling, because it provides important information for the treatment process. Revisit the happiness scale every 2 weeks as a way to monitor adolescents' ongoing progress in treatment. Therapists have found the happiness scale helpful when an adolescent is nonverbal or is providing very little information because it provides a starting point for discussion in several areas.

Complete the *Goals of Counseling* form during the first two or three sessions. Like the happiness scale, the goals of counseling can be revisited throughout therapy. New issues that the adolescent wants to address may

emerge, or further clarification of old issues may prompt new goals to work on. Like the functional analysis of substance use behavior and the functional analysis for prosocial behavior, the goals of counseling should be thought of as a work in progress. The *Happiness Scale* and *Goals of Counseling* forms are described together in this section, but remember that the happiness scale is always an option to be used independently at any time.

Materials

General materials include snacks (e.g., chips, crackers, granola bars, fruit bars), drinks (e.g., milk, fruit juice, caffeine-free soda), chairs, and (if applicable) a videocamera and videotapes or an audiotape recorder and audiotapes.

Procedure-specific materials include happiness scale materials, a clipboard, pens, and a *Happiness Scale* form.

Goals of counseling materials include a clipboard, pens, a *Goals of Counseling* form, and a completed *Happiness Scale* form.

General Notes for the Therapist

Before beginning to use the **happiness scale** or work on the **goals of counseling**, review any available assessment information, including the completed *Functional Analysis of Substance Use Behavior* and *Functional Analysis of Prosocial Behavior* forms. This review will allow you to suggest goals, activities, and reinforcers, based on information the adolescent has already provided, to use in completing the *Goals of Counseling* form.

As always, maintain a positive approach with the adolescent, finding opportunities for reinforcement.

Procedural Steps

1. Provide an overview of the happiness scale and goals of counseling.

2. Ask the adolescent to complete the *Happiness Scale* form, and review it with him or her.

3. Complete the *Goals of Counseling* form with the adolescent.

   - Choose two or three happiness scale categories that the adolescent rated as low to work on.

   - Work with the adolescent to devise a step-by-step intervention so the adolescent can reach his or her goals.

- Decide on a timeframe for completing each intervention or activity. For interventions requiring skills training, indicate when the skills will be taught to the adolescent.

4. Assign homework.

5. Complete the *ACRA Procedure 3 Checklist—Developing the Happiness Scale and the Goals of Counseling* immediately after the session.

Detailed Description

The remainder of this section contains a detailed overview for using the happiness scale and the goals of counseling. Procedural steps are in **bold type** and are followed by further directions and comments. Sample dialogs between a therapist and teenager are in *italic type*.

1. Provide an overview of the happiness scale and goals of counseling.

The *Happiness Scale* form covers 16 areas of life that the adolescent rates on a scale of 1 to 10 indicating how happy or satisfied he or she is with each area of his or her life. These same life areas are repeated on the *Goals of Counseling* form. The 16 areas of life on the happiness scale include the following: marijuana use/nonuse, alcohol use/nonuse, other drug use/nonuse, relationship with boyfriend or girlfriend, relationships with friends, relationships with parents or caregivers, school, social activities, recreational activities, personal habits, legal issues, money management, emotional life, communication, general happiness, and other.

The adolescent rates each area of life on a 1 (totally unhappy) to 10 (totally happy) scale to reflect how happy he or she **currently** is with the particular area. When completed as part of the treatment plan, the happiness scale provides a precounseling baseline that indicates which areas of an adolescent's life are most in need of attention. Blank and sample completed copies of these forms are located at the end of this section. Help the adolescent define specific goals and plans for areas of his or her life in need of attention and set timeframes in which to meet them. Even if the happiness scale reveals that the adolescent is unhappy in many areas of his or her life, it is important not to overwhelm the adolescent by developing too many goals addressing too many different areas of life at once. It is always possible to set new goals as the teen is ready to work on them.

The following dialog is an example of how to introduce the *Happiness Scale* form.

Therapist: *Today, Jim, we are going to work on coming up with the best treatment plan for you. To help us do that, there are two forms we are going to fill out together. The first one is called the* Happiness Scale. *The purpose of this scale is to help us get a clear idea about how satisfied you are right now with different*

areas of your life. It will also help us pinpoint which areas of your life you might want to work on. The second form is called the Goals of Counseling. *On this form, we will list specific goals that you want to reach during treatment and then devise a plan for you to reach those goals.*

2. Ask the adolescent to complete the *Happiness Scale* form, and review it with him or her.

Explain the directions for completing the *Happiness Scale* form. Give the adolescent the scale and a pencil as you describe it.

When rating each area of life, the adolescent should use the current timeframe—that is, how happy he or she is **today** with the particular area. Also, for areas in which an adolescent indicates some unhappiness, gently suggest, where appropriate, there could be a link between his or her using behavior and unhappiness.

Therapist: *Let's look first at the happiness scale. There are 16 categories on the happiness scale. The first 14 have to do with specific parts of your life that we'd like to look at, like number 5, your relationships with your friends, or number 6, your relationships with parents or caregivers. The last two are general categories called general happiness and other. As you go through each item on the form, I'd like you to rate how happy you are right now with that part of your life, using a scale of 1 to 10. A rating of "1" in a life area means you are totally unhappy with that part of your life now—about as unhappy as you could be. A rating of "10" means you are totally happy with that part of your life right now—you are totally satisfied and that part of your life doesn't need any changes. All the numbers in between are less extreme—the lower numbers (2 through 5) mean you are more unhappy with that area, and the higher numbers (6 through 9) mean you are happier with that area. Let's look at the first one together: marijuana use/nonuse. Using the 1 to 10 scale, how satisfied or happy are you right now with that part of your life?*

When reviewing the adolescent's responses, start with areas of his or her life that he or she has rated high. This encourages the teenager to talk and helps build rapport. It also provides an opportunity to learn about what is going well in the adolescent's life and what strengths he or she has in different areas. Later, discuss areas that have been rated low or that are more emotional (e.g., the relationships with his or her parents or alcohol or marijuana use).

In discussing the adolescent's ratings, urge him or her to tell more about why he or she rated areas in certain ways. For example:

> **Therapist:** *A 2 rating means you're pretty unhappy with that part of your life. Tell me a little bit about why you decided on a 2 rating? What made you decide to rate it a 2?*

As mentioned above, it is a good idea to revisit the happiness scale every 2 weeks as a way to monitor the adolescent's ongoing progress in therapy. The goal is to help increase his or her happiness in different aspects of life. If an adolescent's ratings go up (become more positive), ask the reasons for the change. Use the change as an opportunity to reinforce something with the adolescent.

> **Therapist:** *It looks as if there are some things you feel good about. Tell me what has happened in your relationships with your friends that you feel better about.*

If the ratings go down, explore with the adolescent the reasons for the unhappiness, adding new goals to the *Goals of Counseling* form if necessary. Consider, however, that things sometimes get worse at first because the adolescent begins to think more about the situation.

3. Complete the *Goals of Counseling* form with the adolescent.

The same 16 areas of life listed on the *Happiness Scale* form are repeated on the *Goals of Counseling* form. This form has two purposes: to help the adolescent **set specific goals** for each of the major problem area and to **develop plans to address each goal**. The form is set up to reflect these purposes. The first column contains the list of 16 major areas of life listed on the happiness scale. In this column, an adolescent records specific goals related to his or her major problem area. The second column, labeled intervention, is for recording the specific steps the adolescent needs to take to meet each goal. In the third column, timeframe, a specified period is indicated to carry out the intervention.

One of the advantages of completing the *Goals of Counseling* form is that it does not focus solely on an adolescent's use of marijuana and alcohol as a problem area. As the areas are reviewed with the adolescent, it becomes clear that you want to help him or her with problems in multiple areas. This knowledge can help break down the resistance of some adolescents.

When completing the *Goals of Counseling* form, it is important to teach the adolescent to adhere to the following basic guidelines:

- Keep statements brief. Goals and plans to reach them should be in the form of simple statements.

- Always state goals or plans positively. This means the adolescent should say what he or she wants and will do, rather than what he or she does not want and will not do.

- Use only specific, measurable behaviors. That is, goals and interventions should indicate how often (e.g., once a week, every day), on what days, or for how long an intervention will be tried. This way, progress can easily be monitored.

Offer guidance and use modeling techniques to show the adolescent how goals and interventions can be stated according to these basic guidelines.

To begin with, choose only one or two areas of life to work on. When deciding whether a particular area needs intervention, consider the adolescent's rating of each area on the happiness scale as well as his or her other input.

When the therapist and adolescent are ready to begin the process of completing the form, they should start with a category from the happiness scale in which the adolescent indicated at least a fair amount of satisfaction. Goal setting and devising interventions for a category with some satisfaction are usually easy for the teen. Give the adolescent several options from among the higher rated items. The following is an example of giving the adolescent options and setting goals:

Therapist: *You already mentioned that you are working on getting better grades at school, and you've rated school low on the happiness scale. You also rated your relationship with your parents as an area you aren't too happy with. Both of these are areas we can set goals for on the* Goals of Counseling *form . . . or there might be another area you have noticed from the happiness scale that you would like to improve. What is one thing you would like to work on or improve?*

Adolescent: *I guess I'd like to get better grades.*

Therapist: *That's great! What type of grades would you like to get?*

Adolescent: *I'd like to get grades as high as I can.*

Therapist: *What particular grade: an A, a B, or a C? What would you be happy with?*

Adolescent: *Well, I'd like to get A's and B's.*

Therapist: *Okay, let's see whether we can put that goal down as something we can work on while you are coming here. Remember, the goal should follow the three guidelines: It should to be brief, positive, and specific. Go ahead and try stating your goal for school, making it fit all of these rules.*

Adolescent: *All right. I want to get A's and B's at school.*

Therapist: *That was great, but let's make it even more specific; tell me when you want to get these grades. By the end of the quarter, or semester, or what?*

Adolescent: *I want to get them by the end of the semester.*

Therapist: *Okay, Jason, let's put this goal down here* [points to problem area/goal section of *Goals of Counseling*]. *You said you would like to get A's and B's in your classes by the end of the semester. Go ahead and write that in. That is a good goal because we can measure it; we can look at your daily work and your report card and see whether you reach this goal.*

Help the adolescent formulate a desired, realistic goal following the guidelines for each area in which the adolescent wants to set a goal. One strategy to help the adolescent devise a goal is to ask him or her to talk about what he or she is dissatisfied with in the problem areas of life. As he or she talks, listen carefully. Ask the adolescent to identify a reasonable goal to work toward that would address the problem area.

Then help the adolescent turn negative statements into positive goals. For example:

- "I hate school" becomes "I want to do better in school."
- "I don't want to go to jail" becomes "I want to change my behavior so I can enjoy my freedom."
- "I get angry all the time" becomes "I'd like to feel happier and more easy going."

Remember to help the adolescent formulate a goal according to the three guidelines. Use the adolescent's own words and reinforcers.

It is not uncommon for a goal to be made up of a number of components. For more complex, potentially overwhelming goals, help the adolescent break the goal down into several smaller, more manageable goals.

Examples of good open-ended questions to help the adolescent formulate these goals include:

- "What would make you happier about school?"
- "What do you want in your relationship with your parents?"
- "What would you like to have happen with your legal issues?"

Remember to steer the adolescent toward reasonable goals—ones that are attainable. Once a goal has been set and recorded in the first column on the *Goals of Counseling* form, work with the adolescent to devise a **reasonable plan (intervention) for reaching the goal**. The same guidelines used for stating goals should also be used to devise plans: Be brief, be

positive, and use specific (measurable) behaviors. Some goals may require more than one intervention. Open-ended questions, such as the following, can help the adolescent begin to develop appropriate interventions:

- "What would make this happen for you?"
- "What would make your relationship with this person better?"
- "How do you see that happening?"
- "What can we do to help you reach this goal?"

The following is an example of this discussion with a adolescent:

Therapist: *The next thing we can do is fill out the intervention blank, the types of things we do to reach the goal. Let's follow the same three guidelines we talked about for setting a goal so we know exactly how you plan to improve your grades. What are some things you can think of that we could do now or you could do later to help you get A's and B's in all of your classes?*

Adolescent: *I don't know. I guess I could study more or something.*

Therapist: *That's a good idea! How much would you be willing to study each week for your classes? Or do you need to study more for some classes than others?*

Adolescent: *I don't need to study for my art class or P.E. class, but I could study about 3 hours each weekend for all of my other classes.*

Therapist: *Great! It is usually helpful to get as specific as we can. Can you tell me when on the weekend you think you can do the extra 3 hours of studying?*

Adolescent: *Well, that's a tough one. I usually stay out late Friday night; so, maybe I could do it on Saturday afternoons.*

Therapist: *Do you really think that will work?*

Adolescent: *Yeah, I think so.*

Therapist: *Okay. Well, it would be good to try it this week, and we can see how it goes. Let's write that right here.* [Point to the intervention column.]

The next step in completing the *Goals of Counseling* form is to assign a timeframe for each intervention in the last column.

Therapist: *Okay. When trying to reach a goal, you will find it helpful to set a timeframe, when you will begin working on it and when you will do a status check to see whether you are doing what you planned to do. When would you like to start studying more?*

Adolescent: *I might as well start this weekend.*

Therapist: *Go ahead and write down that date as the start date for studying. When shall we do a status check to see whether you were able to spend the time on the weekend? Can we check on this in your next session?*

Adolescent: *Okay.*

Therapist: *Well, let's write this time in the timeframe column too, so we will remember to check on that. Sometimes, to help people find options that help in solving problems, we work on problem-solving techniques. In your case we would work on problem-solving techniques to find ways to improve your grades. Would you be willing to do that?* [You and the adolescent work on putting problem-solving techniques in the plan as well.]

Sometimes, a particular intervention may require skills training. In this case, indicate a timeframe for teaching the skill to the adolescent. Let the adolescent know that you will be teaching the skills needed to meet a desired goal. For example:

Therapist: *Jason, I plan to show you a technique that you can use to solve that sort of problem, so don't worry yet about* ***how*** *you are going to reach your goal in the school area. Right now, it's just important that you have set a goal. I will teach you the technique for reaching it. When should we plan to go over that technique? Next week?*

As the *Goals of Counseling* form is completed, monitor the number of intervention assignments the adolescent will be accepting for a given week. Be careful not to overwhelm the adolescent with too many assignments at the same time.

If you and the adolescent are unable to finish the selected categories of the *Goals of Counseling* form, and you believe the adolescent has the skills to do so, assign a few categories for the adolescent to complete at home.

During each session, check with the adolescent and discuss the status of the intervention assignments from the previous week—how did the assignments go? Feedback and support for attempted interventions are essential. If difficulties were encountered, work with the adolescent to make adaptations or devise a new plan. Roleplay parts if needed. In addition,

review with the adolescent any upcoming intervention assignments. Provide any skills training needed and roleplay anticipated difficulties.

Before leaving this section, it is worthwhile to review the following common difficulties encountered when completing the *Goals of Counseling* form (Meyers & Smith, 1995, pp. 93–94):

- Not applying the three guidelines for developing goals. Most people talk about their problems in vague, negative, and nonspecific (nonmeasurable) ways. For example, "I want to have more fun," or "I want to get along with my parents."

- Designing goals and interventions that are too complex, thus making them confusing and difficult to follow. For example, a goal to make the varsity basketball team as a freshman when the adolescent does not have outstanding athletic skills would be difficult to attain.

- Leaving out important steps that are needed to work toward a certain goal. For example, to improve his or her grades, a student would need to increase the amount of studying he or she does every week, not just for 1 week.

- Including plans that are not really under the control of the adolescent. For example, if a teenage boy wants go out with a specific girl, he cannot control whether she wants to go out with him.

- Placing the adolescent in a high-risk using situation. For example, if you know from the functional analysis of substance use that a certain person's house is a trigger for substance use, you would steer the teenager away from planning to study at that house.

As noted earlier, it is recommended that the happiness scale be revisited every 2 weeks. Ratings on the scale will probably fluctuate as issues are resolved and new ones appear in the adolescent's life. Thus, it may be necessary, or even desirable, to revisit the *Goals of Counseling* form and create new goals as the adolescent's life and issues proceed. The *Goals of Counseling* form is a work in progress and should reflect an adolescent's needs as they change.

Working with a resistant adolescent. The following dialog between an adolescent and a therapist illustrates how a therapist might approach filling out the *Goals of Counseling* form with a resistant adolescent. The adolescent has completed a *Happiness Scale* form in this session, and the therapist and adolescent have already discussed the high and low scores and why the adolescent rated areas the way that he did.

Therapist: *Thanks, Josh! I appreciate your letting me know how things are going for you. Now I'd like to turn to some goals that we can work on together while you are here in treatment. Since you rated school as the area you*

are most dissatisfied with on your happiness scale, let's talk more about that area. You mentioned that the reason that you are unhappy is that you wanted to graduate with all of your friends this year and that you don't think you are going to be able to. [Therapist pulls out the *Goals of Counseling* form and shows it to the adolescent.]

Adolescent: *I ain't filling out no damn form, and what makes you think that I don't already have goals of my own.*

Therapist: *That's cool. We don't need this form. Tell me about the goals that you have.* [Therapist decides not to use the form. She will conduct the goals of counseling part of the session verbally.]

Adolescent: *I told you! I want to graduate with my friends.*

Therapist: *What makes you think that you aren't going to graduate?*

Adolescent: *I have been missing a lot of school lately because I got suspended for fighting. I definitely can't miss any more. Or then I will not graduate. My principal already told me that.*

Therapist: *How much have you missed?*

Adolescent: *All together?*

Therapist: *Yes.*

Adolescent: *About 3 weeks total this semester. I was suspended for 1 week and missed a couple of days here and there throughout the year.*

Therapist: *What was going on the days that you weren't suspended?*

Adolescent: *Just slept late and skipping . . . hanging with friends.*

Therapist: *What do you think you have to do to graduate with your friends? What are some of the things that need to happen?* [Therapist tries not to tell client what he does and does not need to do. She tries to have client verbalize steps. This increases the probability that the client will take ownership of or become invested in the steps needed to accomplish the goals.]

Adolescent: *I need to go to school every day for the rest of the year and make sure that I pass my math class, which I am failing.*

Therapist: *Sounds as if you really know what you need to do to get there.*

Adolescent: *Yeah.*

Therapist: *Do you think you will be able to get to class daily and be able to pass math?*

Adolescent: *I think so.*

Therapist: *You are doing great. You have goals, know what you need to do achieve them, and you are a very smart guy. You seem to have all of this figured out; you know exactly what needs to be done and can see it. I have problems trying to keep all of these things you are telling me straight in my head. It gets overwhelming for me at times. Do you mind if I take notes on what we are talking about to see if there is any way that I may be able to help you with this goal of yours?*

Adolescent: *Yeah, that's okay.*

Therapist: *Thanks. So your goal is that you don't want to have to graduate with any other class than your current class.* [Therapist writes notes as if she needs it herself. She will look at it later with client to illustrate his plans to work on his goals and refer back to it in future sessions.]

Adolescent: *Yes.*

Therapist: *I like to write goals in a positive way. How would I be able to say that in a positive way?* [Attempts to break down the steps of goal setting.]

Adolescent: *Listen, I don't know what the hell you are talking about.*

Therapist: *How would you tell me your goal in a positive way?* [Continues to deal with resistance, not arguing or confronting.]

Adolescent: *I want to graduate this year with my friends?*

Therapist: *Yes, great! Thank you! Now tell me again the steps you are going to take to get there?*

Adolescent: *Go to school every day and pass math. Damn, how many times do I have to tell you?*

Therapist: *You seem irritated. I'm sorry, I am just trying to get all of this down so I can remember. I really appreciate your help. And how are you going to be able to get there every day?*

Adolescent: *Just get up and go.*

Therapist: *You stated you oversleep a lot. What kind of things will you do to make sure you get up?*

Adolescent: *I am going to set my alarm, try to go to bed earlier, and have my buddy come by the house to give me a ride. And if I'm not up, I can have him wake me up.*

Therapist: *You've got all of this all figured out, don't you? You are a good planner.* [Gives praise and positive reinforcement whenever possible.] *That's good because I would really like to see you graduate with your friends also. So you will set your alarm, go to bed earlier, and have your friend help get you up.* [Reflects and summarizes.] *What else can you do to make sure you get there?*

Adolescent: *I guess I can have my mom help me get up too.*

Therapist: *Sounds as if you have several ways in mind to help you get there. And what are your plans for improving your math grades so you won't fail?*

Adolescent: *I don't know. That teacher just doesn't like me. She's a mean piece of work.*

Therapist: *Why doesn't she like you?*

Adolescent: *She just doesn't. She thinks I'm a troublemaker. So she's always on me.*

Therapist: *So what is it about math that you are having problems with? Is it just the teacher?*

Adolescent: *No. I haven't been doing my homework. I hate math and don't want to do it. At this point I am so far behind.*

Therapist: *So you are feeling pretty overwhelmed at this point?* [Encourages reflection.]

Adolescent: *Yes.*

Therapist: *So how can we get that grade up? Let's brainstorm some possible ideas. Can you think of any right off?*

Adolescent: *I could do my work the way I am supposed to.*

Therapist: *Good. You mentioned that you were far behind and hate math. What are some ways that we can get you caught up and back on track?*

Adolescent: *I can go to class and pay attention.*

Therapist: *Good. Going to class is the first step, isn't it? When you go to class, you're not paying attention?*

Adolescent: *No. Usually writing letters to my friends or sleeping.*

Therapist: *So paying attention would probably help a lot. What else would help?*

Adolescent: *Doing my homework; asking parents, friends, and teachers for help; and studying the way I should.*

Therapist: *That is a good plan. Even though you don't get along with your math teacher, would you being willing to share your goal with her—that you may have made mistakes in the past but that you are really ready to work at it now? Possibly asking her what you could do to try to catch up?*

Adolescent: *I can. But like I told you, she's mean and probably doesn't even want to hear me.*

Therapist: *All we can do is try. That is something that I can help you with. We can talk about how to get her to hear you. We could even possibly go to talk to her together if you would like. Would you be up for that?*

Adolescent: *That's cool I guess.*

Therapist: *Good. You have a lot of great ideas on how to accomplish this goal of yours. When thinking about goals, sometimes it is important to put timeframes on them. Here, let's take a look at the notes I scribbled down on how you want to get to where you want to be.*

The therapist and client look at the *Goals of Counseling* form. Together, they determine timeframes for each step or intervention. The therapist then summarizes the goal, interventions, and timeframes discussed.

4. Assign homework.

Help the adolescent decide on a homework assignment related to accomplishing the goals listed on the *Goals of Counseling* form. At the next session, review progress toward completion of the goals.

5. **Complete the *ACRA Procedure 3 Checklist—Developing the Happiness Scale and the Goals of Counseling* immediately after the session.**

A blank copy of this form is included at the end of this section.

Happiness Scale

Name:_____ Adolescent ID:_____ Date:_____

This scale is intended to estimate your *current* happiness with your life in each of the 16 areas listed below. You are to circle one of the numbers (1 to 10) beside each area. Numbers toward the left side of the 10-unit scale indicate various degrees of unhappiness, whereas numbers toward the right side of the scale reflect increasing levels of happiness. Ask yourself this question as you rate each area of life: "*How happy am I today with this area of my life?*" In other words, state according to the numerical scale (1 to 10) exactly how you feel today. Try to exclude yesterday's feelings and concentrate only on today's feelings in each of the life areas. Also, try *not* to allow one category to influence the results of the other categories.

	Completely Unhappy									Completely Happy
1. Marijuana use/nonuse	1	2	3	4	5	6	7	8	9	10
2. Alcohol use/nonuse	1	2	3	4	5	6	7	8	9	10
3. Other drug use/nonuse	1	2	3	4	5	6	7	8	9	10
4. Relationship with boyfriend or girlfriend	1	2	3	4	5	6	7	8	9	10
5. Relationships with friends	1	2	3	4	5	6	7	8	9	10
6. Relationships with parents or caregivers	1	2	3	4	5	6	7	8	9	10
7. School	1	2	3	4	5	6	7	8	9	10
8. Social activities	1	2	3	4	5	6	7	8	9	10
9. Recreational activities	1	2	3	4	5	6	7	8	9	10
10. Personal habits (e.g., getting up in the morning, being on time, finishing tasks)	1	2	3	4	5	6	7	8	9	10
11. Legal issues	1	2	3	4	5	6	7	8	9	10
12. Money management	1	2	3	4	5	6	7	8	9	10
13. Emotional life (feelings)	1	2	3	4	5	6	7	8	9	10
14. Communication	1	2	3	4	5	6	7	8	9	10
15. General happiness	1	2	3	4	5	6	7	8	9	10
16. Other	1	2	3	4	5	6	7	8	9	10

Sample
Happiness Scale

Name:_____ **Adolescent ID:**_____ **Date:**_____

This scale is intended to estimate your *current* happiness with your life in each of the 16 areas listed below. You are to circle one of the numbers (1 to 10) beside each area. Numbers toward the left side of the 10-unit scale indicate various degrees of unhappiness, whereas numbers toward the right side of the scale reflect increasing levels of happiness. Ask yourself this question as you rate each area of life: *"How happy am I today with this area of my life?"* In other words, state according to the numerical scale (1 to 10) exactly how you feel today. Try to exclude yesterday's feelings and concentrate only on today's feelings in each of the life areas. Also, try *not* to allow one category to influence the results of the other categories.

	Completely Unhappy									**Completely Happy**
1. Marijuana use/nonuse	1	2	3	4	(5)	6	7	8	9	10
2. Alcohol use/nonuse	1	2	3	4	5	6	7	(8)	9	10
3. Other drug use/nonuse	1	2	3	4	5	6	7	8	(9)	10
4. Relationship with boyfriend or girlfriend	1	2	3	4	5	6	7	8	(9)	10
5. Relationships with friends	1	2	3	4	(5)	6	7	8	9	10
6. Relationships with parents or caregivers	1	2	(3)	4	5	6	7	8	9	10
7. School	1	2	3	4	5	6	7	(8)	9	10
8. Social activities	1	2	3	4	5	6	7	(8)	9	10
9. Recreational activities	1	2	3	4	5	6	7	8	(9)	10
10. Personal habits (e.g., getting up in the morning, being on time, finishing tasks)	1	2	3	4	5	6	7	(8)	9	10
11. Legal issues	1	2	3	4	5	6	7	8	(9)	10
12. Money management	1	2	3	4	5	6	7	8	(9)	10
13. Emotional life (feelings)	1	2	3	4	5	6	7	(8)	9	10
14. Communication	1	2	3	4	5	6	7	(8)	9	10
15. General happiness	1	2	3	4	5	6	7	(8)	9	10
16. Other	1	2	3	4	5	6	7	8	(9)	10

Goals of Counseling

Name:_____ Date:_____

Problem Areas/Goals: "In the area of _____ I would like to"	Intervention	Timeframe
1. Marijuana use/nonuse		
2. Alcohol use/nonuse		
3. Other drug use/nonuse		
4. Relationship with boyfriend or girlfriend		
5. Relationships with friends		
6. Relationships with parents or caregivers		
7. School		
8. Social activities		

Goals of Counseling

Name:_____ Date:_____

Problem Areas/Goals: "In the area of _____ I would like to"	Intervention	Timeframe
9. Recreational activities		
10. Personal habits (e.g., getting up in the morning, being on time, finishing tasks)		
11. Legal issues		
12. Money management		
13. Emotional life (feelings)		
14. Communication		
15. General happiness		
16. Other		

_____ _____ _____ _____

(Participant's Signature) (Date) (Counselor's Signature) (Date)

_____ _____ _____ _____

(Guardian's Signature—Optional) (Date) (Supervisor's Signature) (Date)

Goals of Counseling

Name: *John Doe* **Date:** *3–1*

Problem Areas/Goals: "In the area of _____ I would like to"	Intervention	Timeframe
1. Marijuana use/nonuse *To be abstinent for 90 days.*	• *Attend weekly therapy sessions, report and discuss progress.* • *Receive problem-solving training (to address difficulties with staying abstinent as they arise).* • *Receive refusal-skill training.* • *Provide random urine sample.*	• *Weekly* • *3/1–6/1* • *3/1–6/1* • *Random during treatment*
2. Alcohol use/nonuse		
3. Other drug use/nonuse		
4. Relationship with boyfriend or girlfriend		
5. Relationships with friends		
6. Relationships with parents or caregivers *I want to improve my relationship with my parents.*	• *Receive communication skills training (practice roleplays with therapist).* • *Receive problem-solving training.* • *Participate in activities with my parents.* • *Report and discuss progress with my therapist.*	• *3/7–6/1* • *3/7–6/1* • *Weekly* • *Weekly*
7. School *I want to get A's and B's in my classes by the end of the semester.*	• *Study at least 3 hours each weekend.* • *Receive problem-solving training (to figure out ways to attain and maintain the grades I want).* • *Ask for help from my teachers, parents, friends, or therapist when I need it.* • *Report and discuss progress with my therapist.*	• *Weekly* • *3/7–6/1* • *Daily if needed* • *Weekly*
8. Social activities		

Goals of Counseling

Name: *John Doe* **Date:** *3–1*

Problem Areas/Goals: "In the area of _____ I would like to"	Intervention	Timeframe
9. Recreational activities		
10. Personal habits (e.g., getting up in the morning, being on time, finishing tasks)		
11. Legal issues		
12. Money management		
13. Emotional life (feelings)		
14. Communication		
15. General happiness		
16. Other		

John Doe (Participant's Signature) *3–1* (Date) *Betty Smith* (Counselor's Signature) *3–1* (Date)

Jane Doe (Guardian's Signature—Optional) *3-1* (Date) *Bill Green* (Supervisor's Signature) *3–1* (Date)

Date _____ Session # _____ Adolescent ID _____ Therapist Init._____

ACRA Procedure 3 Checklist—
Developing the Happiness Scale and the Goals of Counseling

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you review the adolescent's assessment and functional analysis information before developing the adolescent's treatment plan?			
2. Did you maintain a positive approach with the adolescent, finding opportunities for reinforcement?			
3. Did you introduce the treatment planning session to the adolescent, describing the *Happiness Scale* and *Goals of Counseling* forms?			
4. Did you assist the adolescent in completing the *Happiness Scale* form and review it by asking him or her to explain the ratings?			
5. Did you assist the adolescent in completing the *Goals of Counseling* form, teaching the adolescent to adhere to the basic rules of completion?			
6. Did you assist the adolescent in coming up with a homework assignment based on the *Goals of Counseling* form?			

Procedure 4: Increasing Prosocial Recreation

Rationale

Increasing prosocial recreation is an extremely important part of ACRA, and it is important to consider using these procedures in every session. The main way to help adolescents increase prosocial activities is to help them try out or sample new activities. When adolescents do so, they experience timeout from using drugs and the sensation of being clean. Old habits are disrupted, and there is an opportunity to replace them with new, positive coping skills.

Purpose of the Procedure and Learning Objectives

The purpose of this procedure is to help adolescents learn how to increase their prosocial recreational activities to involve acquaintances who are not likely to lead to drug use. This procedure helps adolescents:

- Recognize that being in a situation where they used in the past puts them at risk for relapse
- Identify **prosocial activities** to try
- Understand how to make initial contacts for the new activities
- Identify and enlist **support persons** who can meet them at or accompany them to the new activity
- Become committed to sample new, prosocial activities
- Select a new activity to try as part of the homework assignment.

Timing, Audience, and Delivery Method

Use these procedures beginning in session 2, and reinforce them with the adolescent at every session. This procedure is conducted with the adolescent individually. Emphasize using results from the functional analysis of substance use to pinpoint high-risk times of the week and/or occasions when the adolescent is most likely to relapse. Prosocial recreational activities should be scheduled at these times. The results of the functional analysis of prosocial behavior also provide important background to help schedule prosocial activities.

Materials

General materials include snacks (e.g., chips, crackers, granola bars, fruit bars), drinks (e.g., milk, fruit juice, caffeine-free soda), chairs, and (if applicable) a videocamera and videotapes or an audiotape recorder and audiotapes.

Procedure-specific activity materials include a clipboard, pen, and activity lists from procedure 2.

Reinforcer-sampling materials include activity lists from procedure 2 and a *Functional Analysis of Prosocial Behavior* form.

Systematic-encouragement materials include telephone, phonebook, and activity lists from procedure 2.

Reinforcer-access materials include activity lists from procedure 2, newspapers, phonebooks, and pamphlets from organizations promoting activities (e.g., youth groups, health clubs).

General Notes for the Therapist

Treatment participants usually have developed many social and recreational activities centered on the use of alcohol or drugs. It is therefore normal for youth to find it difficult to find new drug-free activities or friends. Because both adults and youth with drug problems have devoted much of their free time to getting high, they need to sample or reengage in positive leisure time activities to find a drug-free life rewarding. Emphasize to the adolescent that everyone wants to have fun but that there are ways other than getting high to have fun. Encourage the adolescent to believe that together the therapist and the adolescent can find other ways to have fun.

In discussions of new prosocial activities with the adolescent, be both positive and encouraging. Explain that you understand that he or she will, at times, miss previous activities but that reverting to old habits may bring back serious problems or may start the teen on a path toward serious problems.

By using reinforcer sampling (described below), the adolescent learns the appropriate skills to avoid backsliding after a relapse. Searching for new, positive recreational outlets that are incompatible with drug use is a key component of ACRA. In fact, the underlying theory of ACRA is that it helps adolescents create a drug-free lifestyle that is so rewarding that they would not want to return to drug use because of the potential to lose all that they have achieved (e.g., improved family relationships, made new friends, discovered fun activities).

Trying out or sampling new activities provides an opportunity to build rapport. It enables adolescents to set goals that are reasonable and attainable. Meeting these goals promotes their self-efficacy, the belief that they can complete certain tasks. When people believe they can follow through with one task, they are usually more successful at following through with other tasks. Self-efficacy can be generalized to the task of staying substance free.

Access to reinforcers. To do these procedures well, continually update your knowledge about community resources that provide fun, positive, recreational activities (reinforcers). Good sources of information about these activities are local newspapers, youth groups, and service agencies.

Procedural Steps

1. Introduce the topic of increasing prosocial activities.

2. Help the adolescent identify prosocial activities to sample.

3. Use systematic encouragement to support a commitment to sample one or more activities that have been identified.

4. Decide on a homework assignment together.

5. Complete the *ACRA Procedure 4 Checklist—Increasing Prosocial Recreation* immediately after the session.

Detailed Description

The remainder of this section contains a detailed overview of procedures for increasing prosocial activities. Procedural steps are in **bold type** and are followed by further directions and comments. Sample dialogs between a therapist and adolescent are indicated in *italic type*.

1. Introduce the topic of increasing prosocial activities.

The purpose for this session is to help the adolescent identify prosocial activities he or she would like to sample or try. It is important to convey to the adolescent that you understand that many of his or her previous (or current) activities have involved the use of alcohol or drugs. You can set a positive tone by communicating that you will work together to help find new ways of having fun that do not involve alcohol and drugs, while acknowledging that you understand that the adolescent will miss the activities that were enjoyed while using alcohol and drugs in the past. You can help the adolescent recognize that being in a situation in which he or she used in the past puts the teen at risk for relapse behavior.

2. Help the adolescent identify prosocial activities to sample.

High-risk occasions. The functional analysis of substance use provides knowledge about an adolescent's pattern of drug use (e.g., weekend use). These times are the high-risk occasions for using; make these times the primary targets for new recreational alternatives. Review high-risk situations (people, places, things) to set the stage for the adolescent to replace these occasions with positive activities. You might say, "You mentioned you don't want to smoke weed during the next month, and weekends are a high-risk time. Is there some activity that you can think of that will be fun to do during the weekends that does not involve alcohol or drugs? This way you don't have to worry about being put in detention or about your mom getting upset."

Things youth do for fun. Before using this procedure, become familiar with a wide variety of recreational resources available in your community and develop lists of potential activities (see *What Else Can I Do?* and the

Activities That May Interest You examples at the end of procedure 2). These lists can be developed by adolescents in youth groups, in health classes in high schools, in groups of adolescents participating in substance abuse treatment, or in other groups of adolescents who are easily accessible. Review the *Functional Analysis of Prosocial Behavior* form to have a better understanding of triggers and consequences of prosocial behavior that an adolescent may already be participating in.

Reinforcer sampling. Getting an adolescent to try out a new social or recreational outlet may be challenging. One way to encourage this is to frame it as sampling. That is, encourage the adolescent to try it once to see whether there is any potential for enjoying it. For example, you might say, "You mentioned you liked cars. Would you like to go to a car show to see what one is like?"

Keep in mind that many adolescents may have little ability to socially interact with non–drug-using peers. Most of their prior social interactions may have been centered on the drug culture, and drug use may have been a social lubricant for them. So you may need to refer to communication training procedures to help them learn how to make conversation in new groups.

Encourage the adolescent to engage in several new activities that build on each new success. The adolescent is likely to get more out of social occasions if he or she engages in them frequently and makes an effort to be part of the group activities and conversation. For example, if the teen joins a youth group, he or she is more likely to feel a sense of belonging to the group and make friends more easily by attending activities weekly rather than monthly.

It is also helpful if you can work with an adolescent to identify a friend or family member who would be willing to accompany him or her to an identified activity. The adolescent will be more likely to follow through if there is someone with whom he or she can share the planning, transportation, and fun of the activity.

The following is a sample dialog between a therapist and an adolescent about sampling new behaviors:

Therapist: *You didn't mention many activities you like that don't involve alcohol or drugs. I would like to help you find some things you might like to do that don't create some of the negative situations that alcohol or drugs have created for you but that you will have a good time doing. To help you with this, I have a list here that is filled with activities you might like to try or have thought seemed pretty cool. I would like you to read through it and circle anything you would like to do or you already do for fun.* [Gives adolescent an activity list.]

[Looks at list after the adolescent circles activities that he or she is interested in.] *Of all the activities you read through, which one would you the most like to try?*

Adolescent: *Well, laser tag sounded pretty cool. I have a friend who went a few times, and he said it was a lot of fun.*

3. Use systematic encouragement to encourage a commitment to sample one or more activities that have been identified.

If an adolescent says he or she is willing to try a new activity, explore possible obstacles to trying it, and present problem-solving techniques (procedure 7), if needed. Ask the adolescent to identify a good time to try the activity, and get him or her to make a commitment to actually carry it out. Advise the adolescent that structured activities (e.g., a skating party) may be easier to participate in than a party in which the adolescent is alone as far as communicating with others and having a good time. Stress that participation in new activities becomes easier with practice.

An activity list that provides telephone numbers (like the one in procedure 2) is particularly helpful when sampling new behaviors. To encourage the adolescent to find out more about an activity, you may ask him or her to make a telephone call using the list during the session. Before doing so, you should work with the adolescent to develop a list of questions that are appropriate, and then roleplay a typical information-seeking call. It is also appropriate to assign additional calls for homework. Provide encouragement throughout, and praise any successes.

Systematic encouragement. Because it may be difficult for adolescents to engage in a variety of new prosocial activities, Meyers and Smith (1995) recommend three steps for encouraging adolescents: brainstorming, roleplaying, and providing feedback.

Never assume that an adolescent will make a first contact independently. Brainstorm, roleplay, and give feedback to the adolescent on making the initial contact. Brainstorming would center on obtaining information about how to access an activity. You might say, "You said you would like to try rock climbing; how can we find a place to learn how to do this?" You may need to use a problem-solving procedure to help the adolescent figure out how to access an activity.

When roleplaying, it is important to encourage the adolescent's participation. Although roleplaying can be somewhat awkward for some people, it is an important part of encouraging the adolescent to try new activities because it helps him or her visualize and actually carry out what you are asking. When possible, observe the adolescent making the initial phone call. You can observe how well the adolescent does this activity and provide reinforcement for taking this positive step.

- **Enlist social support.** You might ask, "Who are the people who don't want you to smoke weed? Who will help you stay straight?" Whenever possible, identify a support person who can meet or accompany the adolescent to the new activity. This should lessen nervousness about participation and help increase commitment to attending because the adolescent knows someone is expecting him or her.

- **Review the experience** in the next session to determine its reinforcement value. (The activity can serve as a form of homework.)

The following dialog illustrates the use of systematic encouragement.

Therapist: *Great! Laser tag sounds as if it would be a good time. Do you know where your friend went to play laser tag?*

Adolescent: *No, not really. It might be this place in Belleville.*

Therapist: *How do you think we could find out more information to get you set up with laser tag?*

Adolescent: *I guess I could talk to my friend about playing laser tag or call the place in Belleville.*

Therapist: *Sounds good. What type of information would you need to know to play laser tag?*

Adolescent: *Well, I would want to know how much it costs and when they are open.*

Therapist: *And you might want to get directions to the facility, too! Are there any other things you might want to ask?*

Adolescent: *Yeah. How long do you get to play each time?*

Therapist: *Great. Why don't we write down those questions so you will have them later.* [Adolescent writes down questions.] *Why don't we roleplay this to make sure you get everything down to ask when you contact the guy about laser tag.* [Begins roleplaying.] *Say I'm the guy at the laser tag place and you call. "Ring. . . . Hello. This is George at Orbit Laser Tag. May I help you?"*

Adolescent: *Yeah. My name is Jason, and I wanted to know how much it costs to play laser tag.*

Therapist: *It costs $10 for one game and $15 for two games.*

Adolescent: *How long are the games?*

Therapist: *They last 15 minutes each, and you can play with up to 20 people.*

Adolescent: *How late are you open?*

Therapist: *We are open from 11 a.m. to midnight, Monday through Saturday, during the summer.*

Adolescent: *Could you tell me how to get there from Alton?*

Therapist: *Sure. Go to Highway 255 South and turn toward Belleville.*

Adolescent: *Thank you very much.*

Therapist: *That was really good. It sounded as if you got all your questions answered and you were pretty relaxed. How did you feel?*

Adolescent: *All right. I've called places before for stuff, so it was no problem.*

Therapist: *Good. Since you did well with that and had no problem, why don't we try calling the laser tag place and see what kind of information they have about playing there?*

Adolescent: *Okay.* [Adolescent makes phone call.]

Therapist: *That was good. You did a good job of getting the information you needed for laser tag. Do you think your friend who has played laser tag before or Jim* [a nonusing friend] *would like to go to the laser tag place with you?*

Adolescent: *Yeah, I think they would both like it. I can see if they want to do it sometime.*

4. Decide on a homework assignment together.

Sampling prosocial activities will be a frequent homework assignment. Work with the adolescent to get his or her commitment about what will be sampled, with whom, and when.

Therapist: *When do you think you would be willing to try playing laser tag?*

Adolescent: *I don't know, maybe this weekend.*

Therapist: *Okay. Then for homework this week, would you like to try playing laser tag with a friend, maybe someone like Jim or your other friend, at least once before next session? We will talk about it next time and see how it went.*

Adolescent: *Okay. I'll try.*

Therapist: *You can do it!*

5. **Complete the *ACRA Procedure 4 Checklist—Increasing Prosocial Recreation* immediately after the session.**

A blank copy of this form is included at the end of this section.

Date _____ Session # _____ Adolescent ID _____ Therapist Init._____

ACRA Procedure 4 Checklist—
Increasing Prosocial Recreation

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you convey to the adolescent your understanding of the link between his or her previous social and recreational activities and the use of alcohol or drugs?			
2. Did you emphasize that you will work with the adolescent to help find new ways to enjoy free time?			
3. Did you express to the adolescent that you recognize it is likely that he or she will miss the old using activities but that giving in to those feelings may bring back serious problems?			
4. Did you use an activity list to help the adolescent think of new activities to try?			
5. Did you encourage the adolescent to sample new social and recreational outlets?			
6. Using systematic encouragement, did you roleplay on how to make an initial contact and give feedback to the adolescent?			
7. Using systematic encouragement, did you identify a support person to meet or to accompany the adolescent to the new activity?			
8. Did you and the adolescent agree on a homework assignment that included a commitment to actually trying an activity?			
9. If the adolescent committed to an activity in a previous session, did you review the adolescent's experiences in carrying out that activity?			

Procedure 5: Relapse Prevention Skills

Rationale

Relapse prevention begins with the functional analysis of substance use to understand the antecedents and consequences of using. Throughout treatment, therapists need to continue identifying adolescents' motivations for attending treatment and reducing or abstaining from alcohol or drug use. This will help keep adolescents focused on the overall goals they identified early in treatment. Initially, adolescents will have varied success with abstinence or in reducing their use.

Purpose of the Procedure and Learning Objectives

By definition, a relapse occurs after a period of abstinence. This procedure provides information about tools therapists can use when adolescents continue to use substances during treatment or when they relapse after a period of abstinence.

The learning objectives for this session are to help adolescents:

- Understand how to use the **early warning system** to identify high-risk situations
- Understand how to interrupt a chain of events leading to a **relapse**
- Be able to refuse drugs or alcohol assertively
- Change their maladaptive thought patterns and use adaptive ways to respond to relapse triggers.

Timing, Audience, and Delivery Method

This procedure is presented to the adolescent individually and is appropriate for use after an adolescent has had a relapse. With the adolescent's permission, some of the information about relapse may be reviewed with caregivers. This procedure can also be used for relapse prevention and may be periodically reviewed with the adolescent who is putting himself or herself in at-risk situations.

Materials

General materials include snacks (e.g., chips, crackers, granola bars, fruit bars), drinks (e.g., milk, fruit juice, caffeine-free soda), chairs, and (if applicable) a videocamera and videotapes or an audiotape recorder and audiotapes.

Procedure-specific materials include:

- Functional analysis of relapse materials may include a clipboard, pens, and two *Functional Analysis of Substance Use Beahavior* forms.
- Early warning system materials may include a completed *Functional Analysis of Substance Use Behavior* form.
- Behavioral-chain materials may include a chalkboard; whiteboard; pens, markers, or chalk; and an easel (optional).
- Cognitive-restructuring materials may include a completed *Functional Analysis of Substance Use Behavior* form.
- Use-refusal materials may include a chalkboard; whiteboard; and chalk, pens, or markers to visually outline use-refusal skills.

Procedural Steps

1. Identify the adolescent's early warning system.
2. If a relapse occurs, conduct a functional analysis of substance use specific to the relapse situation.
3. Outline the behavioral chain that led to relapse.
4. Provide refusal training.
5. Use cognitive restructuring, if it is developmentally appropriate.
6. Complete the *ACRA Procedure 5 Checklists—Relapse Prevention Skills, Early Warning System, and Cognitive Restructuring* immediately after the session.

Detailed Description

The remainder of this section contains a more detailed overview for conducting relapse prevention procedures. Procedural steps are in **bold type** and are followed by further directions and comments. Sample dialogs between the therapist and the adolescent are indicated in *italic type*.

1. Identify the adolescent's early warning system.

To help treatment adolescents identify and avoid **high-risk situations**, Meyers and Smith (1995) refer to using the triggers section of the *Functional Analysis of Substance Use Behavior* form. Another tool they recommend is the early warning system.

The **early warning system** consists of steps an adolescent can use to help identify when he or she is placing himself or herself in a high-risk situation. It also includes steps to avert a relapse. As part of this procedure, it is important to find out about the adolescent's support system—one or more

persons who know the adolescent is trying to abstain from drugs who are willing to help if the adolescent experiences a warning sign of a relapse. A caregiver, peers, boyfriends and girlfriends, a school counselor, an Alcoholics Anonymous sponsor, or others could be part of the support system. An example of a high-risk situation might be when an adolescent male is repeatedly breaking curfew and hanging out with friends with whom he previously used marijuana. As part of the response to this warning sign, a girlfriend whom the adolescent and therapist have previously identified would call the therapist to let him or her know about this warning sign. The next step in the plan would be for the therapist to see the adolescent as soon as possible to provide direct assistance. A sample dialog for a therapist working with an adolescent to develop an early warning system follows:

Therapist: *Let's talk about something called the early warning system that could help you figure out when you might be doing something that could lead to a relapse. The first thing we need to do is help you become aware of behaviors that may lead to a relapse. The second thing we need to do is figure out what you need to do next if you see yourself starting to do these things. Another important part of this procedure is to identify someone else who can help you during these times. Are you following me?*

Adolescent: *Yeah, I think so.*

Therapist: *Okay, good. What are some triggers or high-risk situations we've talked about before?*

Adolescent: *Well, I used to use when I stayed out late with Jennifer and Bryan.*

Therapist: *Yes, that's what I'm talking about. That's what we found out when we did the functional analysis of substance use. Okay, that is a high-risk situation, and if you started doing that again, what do you think might be a way to stop putting yourself in that situation?*

Adolescent: *Well, maybe I could talk about it with you.*

Therapist: *Yes, I think I could help you. What we find, however, is that often teenagers don't necessarily want to call their therapist when they find themselves in these situations. It seems to work better if a friend or a parent calls the therapist at these times. Then the teenager is likely to follow through with seeing the therapist and talking about the high-risk behavior. Is there someone you would like to call me if he or she sees you starting to stay out late with Jennifer and Bryan again? Your mother? Your girlfriend, Tracy? This would be someone*

we would tell all about the plan and ask to notify me if he or she saw you doing these things again.

Adolescent: *Well, I guess it could be Tracy.*

Therapist: *Would you be willing to have Tracy come in here so we can talk about this plan with her and make sure that we are all on the same page about this?*

Adolescent: *Yeah, we could do that.*

Therapist: *That's great! If you can bring her in next time, we will explain to her exactly what she needs to do.*

2. If a relapse occurs, conduct a functional analysis of substance use specific to the relapse situation.

When a relapse occurs, conduct a functional analysis of substance use for the relapse episode. This task provides the opportunity to break down the relapse in detail to determine the behavioral chain preceding the relapse. The *Functional Analysis of Substance Use Behavior* form can be used.

3. Outline the behavioral chain that led to relapse.

After a relapse occurs, it is important to help an adolescent examine the chain of events that led to relapse. Perhaps it was an abbreviated chain of events; for example, when the adolescent attended a party, someone offered him marijuana, everybody was smoking it, so he did too. Perhaps the relapse actually started when the adolescent received a bad report card, was scolded by a parent or caregiver, and then felt bad. To relieve stress, the adolescent went out looking for some friends to smoke marijuana with. By going over an actual relapse, the therapist outlines the chain that led to the relapse.

The purpose of this exercise is for the adolescent to examine steps in the chain of events so he or she can learn to interrupt the chain as soon as it begins and before it leads to using alcohol, marijuana, or other drugs. These steps can be outlined on a whiteboard or chalkboard.

Exhibit III–4 gives an example of the steps in the behavioral chain that led to a relapse for an adolescent named Jake. The steps show how Jake's decisions led him to relapsing. The therapist can work with Jake to help him realize alternative actions and at what points he could have taken them to alter the series of events. For example, when he was angry at his Dad, he could have called a friend to talk about it or gone outside to play basketball to dissipate his stress.

Exhibit III–4:
The Behavioral Chain

Step 1.	Jake and his dad had a big fight. They yelled at each other and even got physical and rolled around on the floor.
Step 2.	Jake felt really angry about the fight and wondered why his dad had to act that way.
Step 3.	Jake went to his room and shut the door. He started thinking about how he would get back at his dad. He also thought that his dad doesn't really care about him.
Step 4.	Jake remembered that some of his friends were getting together that night at one of their houses and that they probably would be smoking marijuana.
Step 5.	Jake sneaked out of his bedroom window and went over to his friend's house.
Step 6.	Everybody he expected to see was there. He got a whiff of marijuana and felt a little uncomfortable about using again, because it had been a while since he had done so. But he really wanted to use.
Step 7.	His friends welcomed him in and were glad to see him.
Step 8.	When the blunt got passed around, he took a hit and continued to smoke blunts as long as they were available.

4. Provide refusal training.

Refusal training is a component of ACRA behavioral skills training. It is worth presenting to an adolescent several times during treatment. The training teaches adolescents to refuse alcohol or drugs assertively. The timing of providing this training varies, but it may be provided before a relapse as part of relapse prevention training or following a relapse. It can be revisited often to ensure the skills are generalizable or to improve the adolescent's confidence in his or her refusal skills.

Adolescents should first review the positive and negative consequences of not using alcohol or drugs. Before using the refusal skills, they should be reminded to think of the rewards of not using alcohol or drugs. When teaching the five techniques presented below, provide an example of each and roleplay a situation in which the adolescent can practice the technique. Roleplaying during the therapy session will increase the likelihood of success when the adolescent encounters the situation outside therapy. Another way to reinforce existing refusal skills is to ask the adolescent to demonstrate how he or she has refused drugs or alcohol in the past. Then ask why he or she refused in that particular instance. This input can provide additional

insight into a possible motivation to refrain from using. Refusal training consists of five techniques, any or all of which can be used, depending on the adolescent or situation.

- **Say, "No, thanks," assertively.** The adolescent must be firm and positive when refusing. If an explanation is needed, then it is acceptable to offer one (e.g., "No, thanks, I'm not feeling well today."). Casual acquaintances and strangers usually will not ask for an explanation. Close friends or family members are more likely to ask for an explanation for the refusal. A prepared excuse (even a false one) may be helpful at this time but may create the need for the adolescent to refuse again later.

- **Watch body language.** It is important for adolescents to refuse alcohol and drugs using both words and body language that indicate that they are serious and confident. Adolescents should practice standing up straight, facing an individual, and stating firmly, "No, thanks." Not doing this may project the idea that the decision to refuse to use alcohol or drugs is not a firm one.

- **Suggest alternatives.** The adolescent can ask for something other than alcohol or drugs. For example, he or she could say, "No, thanks, but I would really like a soda" or "No, thanks, but I would like something to eat."

- **Change the subject.** Changing the subject indicates that the adolescent is not interested in the offer. For example, he or she could say, "No, thanks. Hey, what do you think of that new CD?" or "Have you seen that new movie?"

- **Confront an aggressor.** If someone persists in offering alcohol or drugs despite receiving a refusal, the adolescent may need to confront the individual. This confrontation should be a last resort because it may lead to a counterattack or temporary loss of a friend. He or she can say, "What don't you understand about 'no'?" or "Why is it so important to you that I use when I don't want to?"

5. Use cognitive restructuring, if it is developmentally appropriate.

Cognitive restructuring is a procedure used to identify and change maladaptive thought patterns. It requires a certain level of maturity of cognitive development to use this technique. For example, it may not be appropriate for a 12-year-old, but it may work well for an 18-year-old. Examples of maladaptive thoughts of an adolescent include:

- "Everybody is mad at me anyway; I might as well get high."

- "I had a joint at that party last week; I might as well use this weekend."

- "I haven't smoked a joint for a whole month—using this weekend won't matter."

The two steps in cognitive restructuring are (1) showing an adolescent how negative thought patterns noted in the internal triggers section of the initial functional analysis of substance use have led to use in the past and (2) teaching the adolescent adaptive ways to respond to these relapse triggers. The goal is to restrict negative thoughts. Adolescents need to learn to use positive self-statements to counteract the negative ones. Examples of positive self-statements that counteract the negative thoughts outlined above are:

- "Everybody will be happier with me if I don't start using again."
- "I really did well up until that one slip, and I felt good that I could control my behavior."
- "If I continue to be abstinent, I will be able to get off probation and get on with my life."

To help an adolescent generate positive statements, ask questions that examine the evidence that supports those thoughts. For example, "If you use marijuana, will everyone be less mad at you or will everyone be more mad at you?" or "Do you really think you can use two weekends in a row and not start falling back into old habits?"

Once you help the adolescent examine the evidence behind negative statements, the adolescent should be encouraged to substitute new, positive thoughts that are not associated with using. Encourage him or her to consider these thoughts several times and then examine the feelings associated with the new thoughts.

6. **Complete the *ACRA Procedure 5 Checklists—Relapse Prevention Skills, Early Warning System, and Cognitive Restructuring* immediately after the session.**

Blank copies of these forms are included at the end of this section.

Tips for Individualizing or Dealing With Difficult Situations

- If the adolescent never has a relapse or says that he or she does not have a problem with urges to use:

  Reinforce the need to practice effective coping skills, and then help identify successful strategies the adolescent is using. When the adolescent analyzes coping tactics, he or she strengthens awareness of what works well and can continue using these methods. The original functional analysis of substance use can also be reviewed to help reduce the risk of relapse.

- If there is substance use in the adolescent's home environment:

Substance use by an adolescent's caregivers or siblings is a primary risk factor for relapse. Educate caregivers about this and attempt to enlist their cooperation in seeking treatment for themselves or in refraining from use in the home. As always, encourage attendance at, and link adolescents to, substance-free recreational and leisure activities. If caregivers refuse to discontinue use, the adolescent can be told about enjoyable activities to participate in outside the home when those at home are using. Assist in identifying family and friends who provide positive reinforcement of sobriety maintenance.

- If the adolescent continues to place himself or herself in high-risk environments:

  Stress the importance of not placing himself or herself in these environments. Probe for reasons why he or she does this (e.g., "I don't want to give up my friends.") and address these concerns. If he or she persists in spending time in these environments, emphasize using the skills from refusal training. Train the adolescent in using refusal skills or review the skills. Ask the adolescent to identify other environments or activities that are reinforcing but that do not contain some of the risks that he or she is trying to avoid.

  Another goal is to decrease exposure to risky situations. Try to get the adolescent to agree to avoid some of these situations. One technique is to ask the adolescent to name five risky situations. Then work toward getting an agreement from him or her to decrease his or her exposure to them. For example, ask, "Could you avoid all five for a week?" If the adolescent responds negatively to this request, then use a less rigid approach. For example, "Okay, you can't see yourself avoiding all these situations. Which ones would you be willing to try to avoid?"

- If the adolescent continues to associate with users:

  Adolescents have difficulty staying away from their friends. Usually taking an authoritarian approach about staying away from friends is not effective. Rather, begin to help the adolescent consider the meaning of a "friend" or a positive relationship. Some helpful questions are, "Do your friends support your wishes to stay clean?" "Do they help you not to use?" "Have you talked to them about whether you have to use drugs to hang out with them?" Challenge the definition of a friend if that person (friend) is behaving in ways that make it difficult for the adolescent to abstain. Ask what would work best to keep him or her from using, and have him or her generate two or three options.

  Sometimes it is appropriate to ask the adolescent's friend to attend a session. With the friend present, the therapist and adolescent can review all the refusal techniques and ask for the friend's cooperation in supporting the goal of abstinence.

Date_____ Session #____ Adolescent ID____ Therapist Init._____

ACRA Procedure 5 Checklist—
Relapse Prevention Skills

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you explain the purpose of relapse prevention training to the adolescent?			
2. Did you probe whether the adolescent used since the last contact?			
3. If a relapse occurred, did you conduct a functional analysis of substance use?			
4. Did you base your decision to use the early warning system and/or cognitive restructuring on the adolescent's needs?			
5. Did you provide refusal training and review all five techniques?			
6. Did you have the adolescent list five risky situations and talk about how he or she could handle them?			

Date_____ Session #____ Adolescent ID____ Therapist Init._____

ACRA Procedure 5 Checklist—
Early Warning System

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you choose this intervention to help the adolescent identify and avoid high-risk situations?			
2. Did you explain this technique to the adolescent and a caregiver, a peer, the school counselor, or another concerned person?			
3. Did you arrange to see the adolescent as soon as possible once you were informed of a problem by the caregiver or peer?			

Date_____ Session #___ Adolescent ID____ Therapist Init._____

ACRA Procedure 5 Checklist—
Cognitive Restructuring

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you choose this intervention to identify and change an adolescent's maladaptive thought patterns?			
2. Did you determine that the adolescent's cognitive development was advanced enough to benefit from this technique?			
3. Did you show the adolescent how the negative thought patterns expressed in the internal triggers section of his or her functional analysis led to use in the past?			
4. Did you teach the adolescent adaptive ways to respond to the relapse triggers?			

Procedure 6: Communication Skills

Rationale

Adolescents often have difficulty communicating in a positive manner with a parent or caregiver and other adults in their lives. This difficulty can spiral into negative communication. Factors other than normal adolescence, such as arrested development because of drug and alcohol use and poor models of communication in the home, may also impact their communication skills. Improved communication skills can help the adolescent create more positive relationships in the home and elsewhere.

Purposes of the Procedure and Learning Objectives

The purposes of this procedure are to help the adolescent understand the rationale for developing good communication skills and to help improve **communications skills**. By the end of this session, the adolescent will learn how the ACRA communication techniques are applied to real life situations. These techniques include how to give an **understanding statement**, how to give a **partial responsibility statement**, and how to **offer to help** solve a problem.

Timing, Audience, and Delivery Method

The adolescent and the caregiver receive communication skills training in individual sessions. In a later joint session, they practice these skills with each other (see procedure 11). This allows the adolescent to learn and practice the skills individually before having to practice together with the caregiver. This session should take place by session 6 or by week 5 or 6 of treatment. Training can be scheduled for a particular session, or the topic can be introduced spontaneously. For example, if an adolescent talks about a communication problem with a parent or caregiver or someone else during a session, this is the appropriate time to introduce the technique. The procedure should be revisited frequently because this is a critical area for most adolescents.

Materials

General materials include snacks (e.g., chips, crackers, granola bars, fruit bars), drinks (e.g., milk, fruit juice, caffeine-free soda), chairs, and (if applicable) a videocamera and videotapes or an audiotape recorder and audiotapes.

Procedure-specific materials include the handout *Communication Skills*; a clipboard; chalkboard or whiteboard; pens, markers, or chalk; and an easel for presentation of material on communications skills.

General Notes for the Therapist

The skills outlined in this section should be taught in the context of real communication problems experienced by adolescents with their parents or caregivers and other people in their lives. That is, although the therapist "teaches" the adolescent about effective communication skills, the teaching is grounded in the experiences of the adolescent. The adolescent is not merely a passive recipient but is actively involved in learning. This situation makes the procedures more relevant for the adolescent, and he or she will be more likely to try them outside therapy.

Emphasize that the skills covered in this section can be used to communicate more effectively in real life, not just in a therapeutic setting.

Procedural Steps

1. Introduce the topic of communication, and provide a rationale for developing good communication skills.

2. Assess the current quality of communication between the adolescent and other important people in his or her life (e.g., parent or caregiver).

3. Using real life examples provided by the adolescent, teach the ACRA communication techniques.

4. Roleplay exchanges between the adolescent and another person (e.g., a parent or caregiver), inserting ACRA and general communication techniques whenever they would be helpful.

5. Process each exchange with the adolescent from the perspectives of content and feelings.

6. Assign homework.

7. Complete the *ACRA Procedure 6 Checklist—Communication Skills* immediately after the session.

Detailed Description

The remainder of this section contains a more detailed overview for conducting a communication skills exchange with an adolescent. Procedural steps are in **bold type** and are followed by further directions and comments. Sample dialogs between the therapist and the adolescent are indicated in *italic type*.

1. Introduce the topic of communication, and provide a rationale for developing good communication skills.

Take a few minutes at the beginning to introduce the topic and talk about the importance of communication skills. Find out what reinforcers would

motivate an individual to make behavior changes. For example, an adolescent might say, "I'm tired of all the yelling at my house." Try to find out something from him or her that can be used to encourage a behavior change. Make the key point that just about everyone can improve his or her communication skills.

2. **Assess the current quality of communication between the adolescent and other important people in his or her life (e.g., parent or caregiver).**

In this step, both the adolescent's relationship with parents or caregivers and his or her communication skills are rated using the happiness scale. Use the ratings as a starting place for a discussion of the adolescent's communication skills. To help the adolescent be specific, ask him or her to identify a particular person (such as a parent or caregiver) to think about in relation to his or her communication skills. Next, ask the adolescent about the quality of communication with this particular person when discussing both nonproblem topics (social or typical everyday conversations) and problem topics (the adolescent's drug use, a problem at school or home). Ask how conversations in each of these categories usually proceed. Ask how the communication has been in the past 2 years.

For example, say, "Tell me what happens when you try to talk together about. . . ."

For situations that do not go well (e.g., the parent/caregiver or adolescent gets angry or frustrated or leaves; they get into a fight), listen and observe carefully to understand the dynamics that typically occur between this person and the teenager. To make sure you understand the situation (and to show the adolescent that you are listening), repeat the situation to the adolescent and ask clarifying questions. For example:

Therapist: *Okay. So when you ask your mom to let you go out to do something with your friends, a lot of times she says,"You can't do that because your room isn't clean, and you haven't done any of your other chores." You then get a little angry because you feel as if you are helping out around the house and cleaning your room. So, you say something like, "I've been cleaning! Why don't you look!" Your mom then says,"If you're going to be smart with me, you can just go upstairs because you aren't going out tonight!" Then you usually go outside while your mom is yelling at you to come back in.*

Ask the adolescent how satisfied he or she is with the present quality of communication with the parent or caregiver. If the adolescent is unhappy, ask what he or she would like to have happen when talking to his or her parents or caregivers. Listen to the adolescent, and observe carefully to understand his or her goals.

Assure the adolescent that techniques that will help with communication problems will be taught. Make sure to leave time to roleplay a few situations during the session to practice the techniques before a real life situation occurs.

3. Using real life examples provided by the adolescent, teach ACRA communication techniques.

ACRA has three basic parts to effective communication:

1. Give an understanding statement.
2. Take partial responsibility.
3. Offer to help.

An **understanding statement** brings feelings of empathy into the conversation. It shows others that an adolescent is capable of seeing things from another person's perspective and helps the other person understand the adolescent's perspective. The effect on the other person is a feeling of validation, and this will decrease his or her defensiveness.

A **partial responsibility statement** indicates that the speaker is willing to accept responsibility in creating, or a role in solving, a problem. It does not mean the person is blaming himself or herself or anyone else or that it is up to the other person to solve the problem. It acknowledges that the adolescent shares responsibility for creating or solving a problem.

An **offer to help** is just that—an offer to help solve the problem. Here, the individual thinks of ways to facilitate cooperation from the other person. Used together, these three conversation enhancers communicate that one person wants a change in the other's behavior and is willing to be actively involved and supportive in the process. The outcome is decreased defensiveness and more open lines of communication.

Using an actual situation of poor communication between the teenager and a parent or caregiver, introduce the three ACRA communication techniques where they would be helpful. The techniques are generic; they can be used to discuss virtually any situation more effectively.

Therapist: *Okay, Gina, let's look at the situation where your mom got upset at you after you asked to go out. Let's review that conversation, break it down, and try to see where everyone is coming from and how each of you feels. To help improve things and help you get something closer to what you want, I would like to talk about some different communication skills that may help your conversations have a better outcome.*

One way to tell that people have good communication skills is for everyone to get a little of what they want. If there is something you want, you would like to get it. I know you don't want your parents to give you a hard

time. When you negotiate, often at the end, you can get closer to what you want than you were before.

The first thing I want to talk about is an understanding statement. The understanding statement is really a big part of improving communication because you are first trying to see where the other person is coming from. Doing that will open up the possibility that that person will listen to you. First consider his or her perspective. Let's use the situation that you talked about earlier when you have trouble getting home in time for a curfew. How would your mom be affected by your wanting a ride home by curfew?

Adolescent: *She doesn't want me to get in trouble, but she doesn't want to go out either.*

Therapist: *Why doesn't she want to go out to get you?*

Adolescent: *Because she is already at home and she says I should have made plans for a ride earlier.*

Therapist: *She thinks you should have planned getting a ride from someone before. You could say, "I* ***understand*** *that it's late and you may already be relaxing at home, so going out might be tough."*

What is your perspective? Because you want to tell her where you are coming from so she understands you better. So, from your perspective, what would you say?

Adolescent: *I need a ride home so I don't get in trouble for violating curfew.*

Therapist: *So we answered all these questions. Why do you want to come home? Because you don't want to get in trouble for being out past curfew. Your perspective is that you don't have anyone to give you a ride home, but you need to get home to meet your curfew. What would you like from her in this situation?*

Adolescent: *I want her to give me a ride home, but I don't want her to be seen yelling at me. If I call and she doesn't want to pick me up, I don't want her to come to the front door and yell at me.*

Therapist: *And you don't want to be yelled at in front of your friends. Okay. I understand how you feel. Next, when you make a request, it needs to be brief, positive, and specific. The reason it needs to follow those rules is that if you are brief, it will be easier for someone to get the main thing you want to communicate. If you tell a person something long and drawn out, the person may get lost. You want to say it in a* ***positive****, nice way so the person is more likely to listen to what you are asking for. You don't want to ask for something in a negative way because the person may respond in a negative way. You need to be* ***specific****, so everyone understands where you are coming from.*

For example, when you ask to be picked up and you aren't specific, your mom may think you mean right now, and you may mean in the next 2 hours. When she comes by, you may be upset because you wanted more time to hang out with friends. So a real problem arises. Okay, following the rules of being brief, positive, and specific what might you say to your mom?

Adolescent: *Would you please come to pick me up, and wait outside?*

Therapist: *At what time would you like to be picked up?*

Adolescent: *I don't know. In an hour.*

Therapist: *Okay. That's really good. So what I might say using the understanding statement is, "Mom, I* ***understand*** *it's late and you may not want to go out, but I am out someplace without a ride and I want to be home so I don't get in trouble for curfew. So I would really appreciate it if you could pick me up at my friend Julie's house in an hour and honk the horn when you need me to come out."*

Let's try it again. This time, let's pretend that I'm your mom, and you can talk to me using the understanding statement.

Adolescent: *I understand it's late and you want me home, and I really want to be home to beat curfew too, but I am stuck here without a ride and can't get home. So I'd really like it if you could pick me up at my friend's house in an hour.*

Therapist: *Great. You did a good job. You came from her perspective, then yours, and you made a request to get picked up at your friend's house in an hour.*

Remember when you are coming from the other person's perspective, you want to tell why that may be difficult for him or her. So you would want to say something like, "Mom, I understand it's late and you may not want to come out and get me," because that is why she may not like it, okay? Let's try it again coming from her perspective, coming from your perspective, and then making a request. You did a really good job with that part before.

Adolescent: *Okay. Mom, I know it's really late and you don't want to come out. And I should have made sure earlier that someone could take me home, but I am stuck here without a ride and don't want to be out past curfew. So, I would really like it if you could pick me up at my friend's house in an hour.*

Therapist: *Good, you had all the parts of the exercise in that one. You made sure to come from her perspective to show that you understand how she is feeling about the whole situation. You also did something else that was really cool when you talked about how you should have made sure there was someone to take you home! This is called taking partial responsibility. Taking partial responsibility is when you say how something you did might have contributed to the problem. When you do this, it shows you don't blame the other person for the problem, and he or she is more likely to listen to you. You want to make sure and say something like this in any situation where the person you are talking to sees you as part of the problem. After taking partial responsibility, I like to restate the request just to keep everyone on track about what I am talking about. So, adding the partial responsibility statement, I might say something like,"Mom, I understand it's late and you are probably tired and don't want to go out, but I am stuck over at my friend's house without a ride and want to get home before curfew. So I would really like it if you could pick me up in about an hour. I understand that I should have gotten a ride and I am sorry about that, but I would really appreciate it if you could pick me up in about an hour at my friend's house." Do you understand how I restated the request?*

Adolescent: *Yeah.*

Therapist: *Okay, let's try it from the top.*

Adolescent: *All right. Mom, I know it's late and you are tired, but I am stuck at my friend's house and I need a ride, so I would really like it if you could pick me up at my*

friend's house in about an hour. I know I should have made sure someone could take me home before I left, but I would really like it if you could pick me up at my friend's house in an hour.

Therapist: *Great! That was perfect. You told her exactly how you fit into the problem. The last part is to make an offer to help. It isn't too tough. It's just figuring out what you can do to make it more likely to get what you want—to be picked up by mom late at night. What you want to do is make sure she is involved in the solution, so she is more likely to come to a decision that both of you like. So, for this part, I first want to offer a few suggestions such as,"If there is anything I can do to help, maybe give you some gas money for picking me up or mow the lawn tomorrow, I would be willing to do it. Or, if there is anything else you can think of, I would be willing to listen." In that last part, I opened it up to her so she could give a few suggestions for solving the problem to make things easier for her. I also said I would listen or consider it. That way I am not saying I will just do whatever she says as a suggestion, but I will listen to what she says and come to a compromise, something that works out for both of you. So it gives you something closer to what you want. Let's try the whole thing since you did such a good job adding in the partial responsibility statement last time. Remember, first do the understanding statement, then the partial responsibility statement, and then add the offer to help.*

Adolescent: *Okay. Mom, I understand you are tired and may not want to go out, but I am stuck at a friend's house and I really want to be home before curfew, so I would really appreciate it if you would pick me up at my friend's house in about an hour. I know I should have had a ride set up before, but I would really like it if you could pick me up at my friend's house in about an hour. If I can do something like give you gas money or anything else, I would be willing to do it or if you can think of anything else, I would listen. I just would like it if you could pick me up at my friend's house in an hour.*

Therapist: *Good job. You did that just right. First you had a good understanding statement from your mom's perspective and then your perspective, then you had a good statement of partial responsibility, and I really liked your offer to help.*

4. Roleplay exchanges between the adolescent and another person (e.g., a parent or caregiver), inserting ACRA and general communication techniques whenever they would be helpful.

When doing the roleplay, insert ACRA and effective communication techniques whenever they would be helpful. Mention pitfalls (e.g., avoid blaming people or rehashing old problems) to avoid if they arise. Point out barriers to communication when they occur. After that, switch roles.

To help improve the effectiveness of the adolescent's communication techniques, the adolescent and therapist should conduct additional roleplays followed by the therapist's feedback. The adolescent can generalize these skills to many areas of life, so these roleplays should cover many problems and issues. After each roleplay, review it thoroughly and help the adolescent reword the conversation to be more effective. Both general communication techniques (e.g., use of "I" statements rather than "you" statements as well as active listening) and those used in ACRA should be introduced whenever they may help.

It is important to provide an opportunity for several roleplays. Roleplaying can be awkward for some people, but it is important for the therapist to encourage the adolescent to participate fully. If you ask the adolescent, "Do you want to do a roleplay?" the answer will often be, "No." So a more subtle approach may be preferable. One way to reduce the awkwardness might be to avoid using the word "roleplay." Instead, you can say something like, "OK, let's just pretend I'm your mother and let's practice some of the ways of talking about what we were just discussing." Stress to the adolescent that it is acceptable for him or her to leave the role to ask questions or get advice. Also remember that it is desirable for the adolescent to have the experience of playing both roles—that of the parent and that of the adolescent.

Numerous pitfalls can occur when two people are attempting to communicate with each other. Two common pitfalls occur when one person blames the other person and when one person brings up an old transgression or behavior. These pitfalls should be pointed out to the adolescent, and they should be avoided.

The *Communication Skills* handout is a helpful teaching device that can be given to a caregiver or adolescent when reviewing communication skills. Have a copy for the adolescent to review. (A copy of this handout is at the end of this section.)

5. Process each exchange with the adolescent from the perspectives of content and feelings.

Following each roleplay, the therapist and adolescent should discuss the conversation. Ask the adolescent, "How did it go? What was different about the conversation compared to how it usually feels? How did it feel for you to play the role of your parent? How do you think your parent would respond to this style of communicating?"

Working with a resistant adolescent on communication skills. The following dialog between an adolescent and a therapist illustrates how a therapist might approach communication skills training with a resistant adolescent. In this case, the adolescent has already attended a couple of sessions, and at the last session he rated school and his relationship with his parents low on the *Happiness Scale* form.

Therapist: *How was your week?*

Adolescent: *Okay, I guess.* [Adolescent responds with short answers, looking down and not wanting to talk.]

Therapist: *How is school going?*

Adolescent: *Okay.* [Continues to give short answers.]

Therapist: *Tell me how you and your mom are doing.* [Therapist asks open-ended questions.]

Adolescent: *She's getting on my nerves.*

Therapist: *Tell me more about that.*

Adolescent: *She's constantly complaining.*

Therapist: *What kind of things is she complaining about?*

Adolescent: *You name it.*

Therapist: [Therapist sits in silence for a while giving the teen an opportunity to respond without constant questioning and then, trying to elicit details, responds.] *Give me an example.*

Adolescent: *Well, like last night, she was angry with me because I didn't get home by curfew.*

Therapist: *What was her response when you got home?* [Trying to find something that the client would invest time in to work on, the therapist does not question why the adolescent was not home by curfew.]

Adolescent: *She started yelling at me.*

Therapist: *Is that her typical response when she is angry?*

Adolescent: *Yeah.*

Therapist: *Then how do you respond?* [Tries to assess current state of communication between adolescent and parent.]

Adolescent: *I either yell back or ignore her. She is so controlling. Always wanting to know my every move.*

Therapist: *That sounds as if that is difficult for you. Wonder why she does that?*

Adolescent: *'Cuz she doesn't trust me.*

Therapist: *Why doesn't she trust you?*

Adolescent: *'Cuz I came home drunk about 2 weeks ago. Now she is threatening to take my car from me.*

Therapist: *Were you driving when you were drunk?*

Adolescent: *Yeah, I had to get home. She wouldn't let me stay at my friends because she doesn't like them and I needed to get the car back.*

Therapist: *Why do you think that your mom would get angry at that?* [Therapist encourages client to try to verbalize mom's feelings rather than takes sides with the youth's mother.]

Adolescent: *'Cuz she is concerned and worried about me. I mean I can understand that. She is just weird about how she handles everything.*

Therapist: *So basically you can understand where your mom is coming from, but you just aren't happy with the way she communicates with you.* [Therapist introduces reflection.]

Adolescent: *Yeah, she is just always yelling at me.*

Therapist: *And when she starts yelling, you either start yelling back or walk away?*

Adolescent: *Yeah.*

Therapist: *It sounds as if your car is very important to you and losing it would be a big deal for you.* [Therapist continues to try to motivate the client to work on communication skills.]

Adolescent: *Yeah! I need it to get to school and work and to go out with my friends.*

Therapist: *Wow. That wouldn't be good then if she took it. Let's think about how we can talk to her to get your point across so she will listen.* [Therapist does not mention

communication skills but nevertheless proceeds to work on these skills.]

Adolescent: *Yeah, okay, like that's going to happen.*

Therapist: *We can try. What do we have to lose? I want to be able to help you have a voice and be able to be heard.*

Adolescent: *Whatever.*

Therapist: *She will be coming in in a couple of weeks with you and that would be a good time to try to talk about some issues you have. While both of you are here, I don't want to have you both yelling at each other the whole time and not hearing the other. So let's talk about how we can get your point across. I'm your mom. Talk to me, and tell me why you think I should not take your car away.* [Assesses state of communication further.]

Adolescent: *I think she is being unfair, and it's bull.*

Therapist: *Good. But talk to me as if I am your mom.*

Adolescent: *That is bull, mom, and you know it.*

Therapist: *Good!* [Therapist offers praise and positive reinforcement even though the response is less than desired.] *Okay. There are a couple of things that I want you to try. First thing is to try to stay positive. Sometimes when people feel on the attack, they get defensive and fight back. And our goal is to try to get her to hear you. The other thing is to try to understand where she is coming from and communicate that. You said earlier that you could understand that she worries when you drink and drive. So you can start by saying to her in a calm voice, "Mom, I understand that, when I drink and drive, you worry and are concerned."* [Therapist uses modeling, coaching.] *Try it.*

Adolescent: *Mom, I understand that you are worried about me, but I don't think you need to take the car away. That is bull, and I told you I wouldn't do it again.*

Therapist: *Great!* [Continues praising for effort and participation.] *You're doing a good job. You did the understanding statement perfectly. After the understanding statement I think it might be helpful to get your point across if you take partial responsibility for your half of what is going on. Then make an offer to come to some kind of agreement or resolution about the car.* [Introduces

shaping.] *I am going to be you for a second and you are your mom. "Mom, I understand that you are worried when I drink and drive. I made a mistake and drove that night. I know that was bad judgment on my part. I was just worried about not having the car home on time, and I know that I should have probably just called you but I was scared. Is there anything that I can do to reassure you that I won't make that same mistake?"*

Adolescent: *I can't talk like that psychobabble! That's not me. Man, please . . . my mom would already be yelling.*

Therapist: *That is a good point. It's kind of weird to talk like that, isn't it? I am going to go over the same stuff with your mom as well, with the goal of trying to have you be able to hear each other's point of view and trying to get you both what you want. I know you said that it was not you, but you sounded great! You made it seem so easy. Have you done this before?*

Adolescent: *They tried to teach us this stuff in residential.*

Therapist: *I am your mom.* [Continues and tries to convince client to continue.] *Talk to me about the issue of the car, starting with the understanding statement, because I think we will have some luck with this and I want to help you get what you want.* [Reinforces rationale for working on communication skills.]

Adolescent: *Mom, I understand that you are worried when I drink and drive.*

Therapist: [Therapist interrupts to help shape.] *Great! Keep going by talking about how you take some responsibility for the night you drank and drove.*

Adolescent: *And I know that I shouldn't be doing that. It was wrong.*

Therapist: *Tell her what your car means to you.* [Helps client through communication skills while shaping, coaching, and encouraging.]

Adolescent: *My car is the most important thing to me. I need it to get around to school, work, and with friends. I don't want to mess it up by driving drunk, and I really don't want you to take it away from me.*

Therapist: *Fantastic!* [Offers praise and positive reinforcement for any effort no matter how big or small.] *Now offer to help or come to some kind of compromise.*

Adolescent: *Since my car is so important to me, how can I get you to trust me again?*

Therapist: *You did great! Did that feel weird?*

Adolescent: *Yeah.*

Therapist: *But you did such a great job! And I think if your mom heard you talk like that, she would hear what you had to say about the issue and would be willing to sit down and talk about it. And I will be here to help you. I know it feels weird, but try it in other situations as well. People are more receptive to hearing what you have to say if you aren't yelling and are trying to understand where they are coming from. This week, practice what we went over.*

By the end of the session, the therapist has reviewed the important parts of communication, has urged the adolescent to practice these skills at home so that he will learn to generalize skills outside sessions, and has praised the client for participation and attendance.

6. Assign homework.

Assign the homework of practicing communication skills. Solicit a commitment from the adolescent to try to put the skills into practice. At the next session, the therapist should review the adolescent's use of the communication skills between sessions.

7. Complete the *ACRA Procedure 6 Checklist—Communication Skills* immediately after the session.

A blank copy of this form is included at the end of this session.

COMMUNICATION SKILLS

The goal of using communication skills is to be able to get your message across to another person to help you get what you want. Using these communication skills should enable individuals to compromise or agree on a solution to a problem. When everyone agrees on a solution, compliance by both sides and contentment with the solution are more likely. It is important to stay positive during the communication skills training and avoid blaming.

Understanding statement. The goal of the understanding statement is to open up communication and show that you are aware of another person's thoughts on a problem. That is:

- ❑ **Come from the other person's perspective.**
  Example: "Mom, I understand you would like my room cleaned because it is a real mess, and you would like the house to be clean when friends come over."
- ❑ **Come from your perspective.**
  Example: "But Jimmy is having a birthday party at his house, and I have not seen Jimmy for a while, so I would really like to go."
- ❑ **Make a request (a request should be brief, positive, and specific).**
  Example: "I would really appreciate if you would let me clean my room later tonight, maybe around 8 p.m. when I get home."

Partial responsibility. The goal of the statement of partial responsibility is to avoid blaming the other person. Remember to state how you or the other person see yourselves fitting into the problem or solution. That is:

- ❑ **How do you fit into the problem?**
  Example: "I know I made a real mess by not putting my clothes away, and I have not always followed through with cleaning my room, and I am sorry about that."
- ❑ **Repeat the request (optional).**
  Example: "But I would really appreciate if you would let me clean my room around 8 tonight after I get home from Jimmy's party."

Offer to help. The offer to help is used to show that you are willing to work on a solution that works for everyone and that you would like input from others on possible solutions. That is:

- ❑ **Offer several possible solutions.**
  Example: "If there is anything I can do to help make that happen—help out with another chore around the house, help out with dinner, or just do a quick 10-minute cleaning for now and do the rest later—I would really appreciate it."
- ❑ **State your openness to listen to and consider the other person's ideas.**
  Example: "Or if there is anything that you can think of, I would be willing to listen."

Following the offer to help, individuals may try to compromise on a solution or do some problem solving. It may be necessary to go through the communication skills again to state your point.

Date_____ Session #____ Adolescent ID____ Therapist Init._____

ACRA Procedure 6 Checklist—
Communication Skills

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you introduce the topic of communication by providing a rationale for developing good skills in this area?			
2. Did you assess the present quality of communication between the adolescent and other important people in his or her life (e.g., parents/caregivers)?			
3. In the context of real life examples provided by the adolescent, did you teach the adolescent to give an understanding statement?			
4. In the context of real life examples provided by the adolescent, did you teach the adolescent how to make a partial responsibility statement?			
5. In the context of real life examples provided by the adolescent, did you teach him or her how to offer to help solve the problem?			
6. Did you roleplay exchanges between the adolescent and another significant person and insert ACRA and general communication techniques whenever they would be helpful?			
7. Did you switch roles with the adolescent?			
8. Did you process each roleplay exchange from the perspectives of content and feelings?			
9. Did you use the *Communication Skills* handout when appropriate?			
10. Did you ask the adolescent to practice communication skills for homework?			

Procedure 7: Problem-Solving Skills Training

Rationale

Problem-solving skills are essential in ACRA. They are general life skills that are valuable beyond the treatment experience. Training adolescents in problem-solving skills teaches them how to handle the problems that come up in life without resorting to the use of marijuana or alcohol to cope. Problem-solving skills increase the adolescent's sense of self-efficacy and self-esteem. With problem-solving techniques, adolescents realize that no matter how insurmountable a problem may appear, it can always be broken down into small steps and conquered.

Purpose of the Procedure and Learning Objectives

The main purpose of this procedure is to improve the adolescent's ability to solve problems in real life situations. The learning objectives are to help the adolescent:

- Understand and practice the three-step problem-solving technique: define the problem, generate alternatives, and choose one solution
- Become aware of the need to evaluate the effectiveness of the solution.

Timing, Audience, and Delivery Method

Problem-solving skills training takes place with an adolescent individually. It can be scheduled for a particular session, or the topic can be introduced naturally when the adolescent brings a problem to the session. Thereafter, every time the adolescent brings up a problem situation, the therapist should reintroduce the problem-solving technique and work through the steps to generate solutions for the adolescent to try out.

Materials

General materials include snacks (e.g., chips, crackers, granola bars, fruit bars), drinks (e.g., milk, fruit juice, caffeine-free soda), chairs, and (if applicable) a videocamera and videotapes or an audiotape recorder and audiotapes.

Procedure-specific materials include clipboard; chalkboard; whiteboard; pens, markers, or chalk; an easel (optional); and the handouts *How Do I Solve That Problem?* and *How Can I Solve This Problem?* (optional).

General Notes for the Therapist

Maintain a positive atmosphere for change throughout problem solving. This positive atmosphere is created by a positive demeanor, an enthusiastic tone of voice, positive expectations for change (a "Yes, you can!" attitude), and praise for the adolescent's behaviors and efforts. Because problem-solving techniques are best learned through practice, listen carefully to the adolescent during sessions for opportunities to introduce or reintroduce problem solving. You can use the adolescent's exact words to describe a problem so that it is apparent that you heard his or her concern.

Problem-solving technique handouts are at the end of this section. Memorize the steps in the problem-solving technique, and give copies of the handouts to the adolescent. The problem-solving technique used in this manual is an adaptation of the problem-solving approach introduced by D'Zurilla and Goldfried (1971). It is taken from Meyers and Smith (1995, p. 106) and used with permission of the copyright holders. A problem-solving form for use by the adolescent is at the end of this procedure. An example of a completed form is also provided.

Procedural Steps

1. **Introduce** (or reintroduce) the technique to the adolescent.

2. Assist the adolescent in **defining the problem** clearly and specifically.

3. Encourage the adolescent to **generate alternatives** for solving the problem.

4. Help the adolescent **decide on one solution**.

5. **Assign homework** based on the chosen solution.

6. Introduce the concept of **evaluating the outcome**, and follow up in a subsequent session by reviewing and evaluating an outcome with the adolescent.

7. Complete the *ACRA Procedure 7 Checklist—Problem-Solving Skills Training* immediately after the session.

Detailed Description

The remainder of this section contains a detailed overview for conducting a problem-solving exchange with an adolescent. Procedural steps are in **bold type** and are followed by further directions and comments. Sample dialogs between a therapist and an adolescent are indicated in *italic type*.

1. Introduce (or reintroduce) the technique to the adolescent.

This is an example of how the technique is introduced as a scheduled topic:

Therapist: *Today, Jim, we are going to talk about a technique you can use to solve problems that come up. Not just problems you encounter during the time you are meeting with me, but problems you will encounter throughout your life, when you're not going through treatment.*

Give the adolescent the handout *How Do I Solve That Problem?* Review the contents with the adolescent. Encourage questions, and praise the adolescent for giving examples and making connections.

Once the technique has been explained, illustrate how to use the technique. Ask the adolescent to mention some current problems that he or she would like to address. Then select a few relatively uncomplicated problems and use the problem-solving technique. Also, the problem-solving technique can be used when the therapist and adolescent are completing the goals of counseling to identify interventions for each goal.

The need for problem-solving training often emerges naturally, for example:

Therapist: *Gina, it sounds as if you have a problem. You're really concerned about bringing your math grade up. You've tried to do it on your own, but it's not working. Let's talk about how you might solve this problem.*

Use the first step of the technique to help the adolescent define the problem. Work with the adolescent step by step through the problem-solving method outlined below. Be generous with your assistance, but let the adolescent take the lead. The adolescent's responses to each step can be written on the outline to further define the technique.

When the adolescent is already familiar with the technique, reintroduce the topic, connect the adolescent's problem and the technique, and proceed through the steps with the adolescent. For example:

Therapist: *Okay, Gina, it sounds as if you have a problem. Remember the problem-solving technique we've used a few times already? Let's see whether we can come up with some solutions to your problem. The technique seemed to work well the previous times. You were so pleased with the outcomes, remember?*

2. Assist the adolescent in defining the problem clearly and specifically.

Give the adolescent a copy of the handout *How Can I Solve This Problem?* The adolescent can use the handout to record his or her responses. Help the adolescent define the problem as specifically as possible. Try to generate open-minded thinking; encourage the adolescent to think about why a problem might exist.

Therapist: *Gina, tell me more about how you're doing in math. I know you said you were failing, but tell me more about how your grade got where it is.*

Adolescent: *We have had three math tests so far. I got a 48 on the first one, so I studied really hard for the second. I got a 32. So then I spent even more time on my math. Then I got a 54. If I fail the next one, I will have to repeat freshman math.*

Separate any secondary or related problems. These are additional problems that may contribute to the problem at hand.

Therapist: *What are some of the things that might be contributing to your difficulty in math class? Can you think of any?*

Adolescent: *Well, when I don't understand something, I don't like to raise my hand in class. I would rather try to figure it out on my own. I also like to watch TV, so when I do my homework, the TV is on; and my brother bothers me when I'm trying to study, and I don't always finish my work.*

Therapist: *Okay, I can see how these things could contribute to having a hard time in math. Let's keep them in mind when we start to come up with possible solutions to your problem.*

3. Encourage the adolescent to generate alternatives for solving the problem.

Use brainstorming to generate as many potential solutions to the problem as possible. Follow two important rules for brainstorming:

- Do not criticize any of the potential solutions. It doesn't matter whether they sound like something the adolescent would never do or whether they're something that has already been tried.
- Go for quantity.

Write all possible solutions on a whiteboard or chalkboard. Do not worry about specificity at this point; you can help the adolescent narrow the choice as he or she picks a solution to try.

Therapist: *The next thing to do is to think of as many solutions as you can without judging them. Remember, we don't want to eliminate any of the possible solutions yet. One thing I can think of is to see a tutor for your math. What's something you can think of?*

Adolescent: *Maybe studying away from the TV or at the library so my brother doesn't bother me.*

Therapist: *Good! Maybe studying with someone who is doing well in class would help.*

Adolescent: *Or just studying more before tests would help.* [Encourages the adolescent to generate as many solutions as possible.]

4. Help the adolescent decide on one solution.

Help the adolescent narrow down the list of alternatives. First, the adolescent should eliminate any solutions that he or she does not feel comfortable trying. No explanations are necessary—tell the adolescent that no explanations are required for eliminating any alternatives.

For the remaining solutions, encourage the adolescent to think about how it would be to carry out each solution. Ask, "Do you think you would actually follow through with the solution? Would it work?" This may narrow down the list even more.

From the pool of remaining solutions, the adolescent should choose one solution and describe exactly how it will be carried out. Again, ask, "Which one would be most helpful?" and encourage the adolescent to be as specific as possible (e.g., when? how often? what time of day? with whom?).

Help the adolescent identify **any obstacles** to carrying out the solution—that is, things that might interfere with the completion of the assignment. The goal is to identify beforehand any obstacles that could possibly subvert the adolescent's attempts to solve the problem. Ask, "What might come up in the course of a week that would get in the way?" As each obstacle is identified, generate backup plans with the adolescent to circumvent it. If the adolescent thinks he or she might forget, for example, then ask, "What can you do to make sure you don't forget?" Spend time talking about these obstacles. Homework assignments may be appropriate. If possible, allow the adolescent to write on the whiteboard or use the computer. Participation in this process will help the adolescent apply lessons learned.

The adolescent should now have a specifically defined plan for addressing the problem. The plan should include when the solution will be attempted, how often, and at what times. The adolescent should agree on the number of times to try the solution before the next session. To reinforce this action, ask, "Now, what did you decide you will do?"

Consider whether additional solutions should be attempted before the next session. If the adolescent wishes to try additional solutions, repeat the decision process for each solution. Evaluate with the adolescent the feasibility of the remaining solutions, choose another solution to try, and describe exactly how it will be carried out, consider possible obstacles to enacting

the solution, and generate a backup plan to overcome the obstacles. A sample dialog between a therapist and adolescent follows:

Therapist: *If there are any solutions that you don't think you would try, go ahead and cross those off. You don't have to explain why; just cross them off if you don't think you would try them.*

Adolescent: *I don't think I would go to the library.*

Therapist: *Okay. We'll cross that one off. Are there any other ones you don't think you would try?*

Adolescent: *No, I think I would try any of the other ones.*

Therapist: *Are there any solutions you think would not work?*

Adolescent: *No, I think they could all work.*

Therapist: *Which one do you think you would like to try the most?*

Adolescent: *I think if I studied with my friend Julie, that would help because she does so well in math.*

Therapist: *How would you go about doing that?*

Adolescent: *Well, I would just call her up and ask her to study with me.*

Therapist: *Good. When do you think you will study and how long will it take?*

Adolescent: *I don't know. Maybe I'll study once during the week and once on weekends, so I'm not having to do it all on the weekends. Maybe I can study 2 hours each time.*

Therapist: *So, twice a week. Are any particular days better than others for you?*

Adolescent: *Wednesdays and Sundays could probably work, but I would really have to ask Julie first.*

Therapist: *Good thinking. Are there any things that could make it difficult for you to do this?*

Adolescent: *Not really. We could study anywhere. I guess if she couldn't study on a certain day, it could be tough.*

Therapist: *If that happens, what would you do?*

Adolescent: *I'll just pick another day. I mean, I can study almost any time.*

5. Assign homework based on the chosen solution.

Help the adolescent identify a homework assignment based on the solution chosen during the problem-solving session.

Therapist: *When would you like to start studying with Julie?*

Adolescent: *Right away probably. I could start tonight.*

Therapist: *Great! Why don't we try calling Julie right now and see whether we can set up your study time?* [Gina makes the call and sets up the study session.]

Therapist: *Good job! I'll check how the studying is going when we meet next week. You are planning on studying twice a week for 2 hours, right?*

Adolescent: *Yeah.*

6. Introduce the concept of evaluating the outcome, and follow up in a subsequent session by reviewing and evaluating an outcome with the adolescent.

Explain to the adolescent that an important part of problem solving is checking whether a particular solution worked. This checking is done by asking the following questions: Was the solution carried out? If not, what barriers got in the way? What could be done differently next time? If the solution was carried out, did it help solve the problem? Was the desired outcome attained? For example, in the solution for the sample above, did the adolescent's grades improve? The adolescent can do the checking himself or herself or during a counseling session.

Review the outcome with the adolescent at the next session. Be sure to positively reinforce any efforts by the adolescent to try to carry out a solution. If solutions did not go well or the adolescent had a difficult time carrying them out, help him or her modify the solution and encourage another try. If an entirely new solution is necessary, repeat the problem-solving steps.

If the adolescent did not attempt the assignment, the lack of followthrough could be treated as a problem that needs a solution. The problem-solving technique could be applied in this situation. Once the adolescent appears to understand the problem-solving technique, he or she should walk the therapist through the procedure step by step using a new problem. Attaining this level of skill is recommended before terminating therapy.

7. Complete the *ACRA Procedure 7 Checklist—Problem-Solving Skills Training* immediately after the session.

A blank copy of this form is included at the end of this section.

HOW DO I SOLVE THAT PROBLEM?

Everyone experiences problems from time to time with things like school, parents, caregivers, friends, work, or activities. Using problem-solving techniques can help us consider every part of a problem to come up with a good solution. Below is an outline of a problem-solving technique you can use when a problem arises.

1. Define the problem.

- ❑ Define the problem as specifically as possible (be brief, positive, and specific).
- ❑ Make sure you are dealing with one problem at a time.

2. Generate alternatives.

- ❑ Use brainstorming (think of as many things as you can) to generate possible solutions.
- ❑ Do not criticize any of the suggestions offered.
- ❑ Go for quantity; the more potential solutions, the better!

3. Decide on a solution.

- ❑ Eliminate any solution you would not feel comfortable trying or you do not think you would do. No explanations are needed.
- ❑ Think about the chances that each remaining alternative will work while checking out its probable consequences.
- ❑ Decide on one solution, and describe exactly how you will carry it out.
- ❑ Consider obstacles that may come up in trying the solution.
- ❑ Generate backup plans in case you run into an obstacle.
- ❑ Decide with the therapist on the number of times you will try the solution before the next session.
- ❑ Decide whether to attempt a second solution as well.
- ❑ Go through the problem-solving steps above, starting with the second step, for any solutions considered.

4. Evaluate the outcome.

- ❑ Review the outcome, and decide how satisfied you are with how it worked out.
- ❑ Modify the solution if necessary.
- ❑ If an entirely new solution is needed, repeat the problem-solving steps.

HOW CAN I SOLVE THIS PROBLEM?

1. What is the problem you are dealing with?

2. What are some ways you might be able to solve the problem? List as many ideas as you can think of.

3. Draw a line through any ideas that you don't think you would try.

4. Read each idea that you have not crossed off the list, and pick one idea that sounds like something you would like to try. Write it down.

5. Try that idea before the next time we get together, and we can talk about how it went.

HOW CAN I SOLVE THIS PROBLEM?

(SAMPLE ANSWERS)

1. What is the problem you are dealing with?
   I am failing math.

2. What are some ways you might be able to solve the problem? List as many ideas as you can think of.
   Study away from the TV.
   Study at the library so my brother doesn't bother me.
   Study with someone who is doing well in class.
   Study more before a test.

3. Draw a line through any ideas that you don't think you would try.
   ~~*Study at the library so my brother doesn't bother me.*~~

4. Read each idea that you have not crossed off the list, and pick one idea that sounds like something you would like to try. Write it down.
   Study with my friend Julie, who is doing well in class.

5. Try that idea before the next time we get together, and we can talk about how it went.

Date_____ Session #____ Adolescent ID____ Therapist Init._____

ACRA Procedure 7 Checklist—
Problem-Solving Skills Training

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you maintain a positive atmosphere for change throughout problem solving?			
2. Did you introduce the problem-solving technique and go over the outline with the adolescent?			
3. Did you help the adolescent clearly and specifically define the problem, separating out any secondary or related problems?			
4. Did you encourage the adolescent to generate alternatives for solving the problem by following the two rules important for brainstorming?			
5. Did you help the adolescent narrow down the list of alternatives and choose one solution?			
6. Did you have the adolescent commit to an agreed-on number of times to try the solution before the next session?			
7. Will you evaluate the outcome at the next session?			

Procedure 8: Urine Testing

Rationale

The results of a urine test are not the focus of ACRA treatment because ACRA primarily relies on identifying reinforcers and taking a positive approach. However, a negative (no drugs found) urine test provides the opportunity to reinforce abstinence, whereas a positive urine test provides additional information to the therapist that can be used to prompt appropriate ACRA procedures (e.g., relapse prevention).

Purpose of the Procedure and Learning Objectives

The purpose of the procedure is to monitor adolescents' abstinence through a means other than self-reports and to provide appropriate feedback to adolescents based on test results. The learning objectives are to provide adolescents with:

- Positive reinforcement and support if the urine test indicates no drugs are present
- Nonjudgmental review of the context of use and triggers if the results indicate that drugs are present
- Potential solutions if a similar using situation is encountered in the future.

Timing, Audience, and Delivery Method

During the CYT study, adolescents were asked to complete urine tests on two random occasions during a 6-week or 3-month intervention. In general practice, the frequency of urine testing may vary, depending on treatment facility requirements. Regardless of the frequency of urine testing, adolescents should be informed about the frequency and general procedures for urine testing during an initial session.

When the adolescent is due for a test, the therapist can approach the adolescent before the session begins and explain that this is the day that has been randomly chosen for a urine test. Reiterate the reason and procedures for completing the test; direct the adolescent to a lavatory; and provide a cup. Read the results and record them in the clinical chart. The entire procedure should take approximately 10 minutes. When the adolescent is not able to provide a sample, ask him or her to give a sample at the end of the session.

Materials

Procedure-specific materials include drinks if the adolescent is having difficulty providing a urine sample, test kits, screening cups, rubber gloves, and watch or clock.

Urine Test Kits

If possible, it is important to use an onsite urine test kit that can be read almost immediately. Kits are available that can test for the primary drugs being abused by a target population. Because these tests can be read immediately, they allow for immediate (same session) feedback and discussion of the results with the participant. Besides the test kits, additional supplies needed to conduct tests include latex gloves, urine screening cups, a directions or procedure sheet for the analysis of the test kit results, a clock or watch to monitor the time that elapses, and access to a rest room.

There are many different brands of onsite drug tests. Typically, these tests are economical, with prices based on the number of drugs being tested for. The tests generally require placing drops of urine on testcards, allowing a certain amount of time to elapse, and then reading the results by examining visual markers. Tests do not necessarily have to be observed if (1) there are procedures built into the test that help detect adulterated samples and (2) there is temperature monitoring so that it is possible to detect watered down samples. Temperature monitoring can be done with specimen cups that have built-in temperature strips. Staff members who handle the urine should be trained in the proper procedures for safely handling bodily fluids. It is also important to study procedures regarding refrigeration of test kits to optimize shelf life.

Note that onsite drug tests are considered to provide preliminary analytical results. Gas chromatography/mass spectrometry (GC/MS) is usually preferred for a confirmatory analysis. These tests are typically done in a laboratory. An onsite test may have limited value in assessing decreasing drug use (as opposed to total abstinence) and does not provide confirmatory analyses that may be required by a court or other source. If a teenager denies use but tests positive with an onsite test, consider sending a second urine sample to a certified laboratory to verify the onsite test using GC/MS.

General Notes for the Therapist

Adolescents should be told in the first session that there will be random urine tests so they are not surprised when the therapist tells them it is time for one. When the therapist discusses the urine test during the initial session, he or she also needs to explain the reason for the test. If the adolescent refuses to submit to a test, it is important for the counselor to continue therapy with him or her because the most important goal is to treat the client. If an adolescent is on probation, the probation officer may conduct the urine test rather than the therapist.

Treatment programs may not want to do urine testing when a teenager freely admits to using unless the particular test being used is one that provides measures of substance use levels.

Note: If the adolescent is absent the week testing is due, administer the test during the next treatment session he or she attends.

If urine testing has been mandated by probation, parole, or another court agency, obtain appropriate signed disclosures and reveal the test results to the agency.

Procedural Steps

1. Explain to the adolescent that he or she will need to provide a urine sample today.

2. Take the adolescent to a bathroom, provide the necessary materials, and go over the instructions for providing a sample.

3. Read the test.

4. Provide the appropriate feedback based on the results.

5. Complete the *ACRA Procedure 8 Checklist—Urine Testing* immediately after the session.

Detailed Description

The remainder of this section contains a more detailed overview for conducting a urine test and processing its results. Procedural steps are in **bold type** and are followed by further directions and comments.

1. Explain to the adolescent that he or she will need to provide a urine sample today.

Urine tests should have been discussed in an earlier session so they will not be a surprise to an adolescent. Tell the adolescent that this session is the one that has been randomly chosen for a urine test. Explain the purpose of the urine test and the possible outcomes, and provide some general idea of what your response will be to each of the outcomes. Also tell the adolescent about procedures that are in place to assess whether a sample has been tampered with.

2. Take the adolescent to a bathroom, provide the necessary materials, and go over the instructions for providing a sample.

Specific steps for conducting the test and an explanation of how it works should be available from the company that markets the tests. The therapist should complete either a company-sponsored or an inhouse training program and be certified before administering tests.

3. Read the test.

Follow the manufacturer's instructions, and read the test results—possible outcomes include negative (drugs are not present), positive (drugs are present), or inconclusive. If the test is inconclusive, you may want to test an additional drop from the same sample. Record the results on the urine-testing form.

4. Provide the appropriate feedback for the results.

When the test indicates that drugs are not present in the urine, provide strong positive reinforcement and social support. Review aspects of the adolescent's living environment that have been conducive to abstinence. Encourage continued development of drug-free activities. Probe for problems with cravings or emotional distress during this time. Find out how the adolescent coped successfully with these problems. Ask the adolescent, "What is your biggest motivation for not using?"

When urine test results indicate that drugs are present, review the context of the adolescent's use. Be nonjudgmental. Examine external and internal triggers associated with his or her use, and generate potential solutions to resist use if a similar circumstance is encountered in the future. Talk with the adolescent about goals for marijuana use and nonuse. Try to get the teen to commit to changing his or her using behavior, and help the adolescent identify personal motivators for staying away from alcohol or drugs. Review triggers, coping methods, and other relapse prevention procedures described in procedure 5 of this manual.

5. Complete the *ACRA Procedure 8 Checklist—Urine Testing* immediately after the session.

A blank copy of this form is included at the end of this section.

Tips for Individualizing or Dealing With Difficult Situations

To individualize urine test results:

- Stick with the specifics of the adolescent's situation.
- Discuss what the adolescent is doing to maintain his or her abstinence.
- Focus on what can be done to avoid triggers and lapses.

If the adolescent denies using despite positive results:

- Do not criticize the adolescent. Rather than being confrontational, play detective and ask questions. For example, "What do you make of this discrepancy?" or "What do you think is going on here?"
- Point out that perhaps a urine test showing drugs in the urine could have consequences (e.g., probation problems, losing a job) even if the adolescent did not use.
- Ask the adolescent how you can help him or her.
- Reiterate that being around others who are using alcohol or drugs is a high-risk situation with negative consequences.

(Continued on next page)

- Ask how the urine test results could affect his or her goals.

  Note: You also may want to suggest sending an additional sample to a laboratory for verification.

Date_____ Session #_____ Adolescent ID_____ Therapist Init._____

ACRA Procedure 8 Checklist—
Urine Testing

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you explain the purpose of urine testing?			
2. Did you record the results in the clinical chart?			
3. If test results were negative, did you provide positive reinforcement and social support?			
4. If test results were positive, did you review the context of the adolescent's use, examining external and internal triggers?			
5. If test results were positive, did you generate potential solutions to use if the adolescent encounters the circumstances again?			
6. If test results were positive, did you review procedures on relapse prevention?			

Procedure 9: Caregiver Overview, Rapport Building, and Motivation

Rationale

Caregivers have an important role in helping the adolescent overcome a drug or alcohol problem. They must therefore be taught the behavioral skills to discourage the adolescent's drug use and the parenting practices that can keep their adolescent from relapsing.

Purposes of the Procedure and Learning Objectives

The purposes of the first session with the caregiver are to (1) **motivate participation** in the ACRA treatment process and (2) help the caregiver understand how his or her behavior impacts the adolescent's substance use. The learning objectives are to provide caretakers with:

- A more **positive attitude** about their adolescent that eliminates blaming anyone for current problems
- An **understanding of the ACRA approach** and treatment process and the importance of their role in the treatment
- Motivation to continue working with the ACRA therapist.

Timing, Audience, and Delivery Method

These procedures are covered during the first session with the caregiver in the first or second week of treatment. During the first adolescent session, you should have already met briefly with the caregiver to provide an overview of the ACRA treatment process and the caregiver's involvement in it. (See the section Sequence and Content of Caregiver Sessions in Part II, Overview of the Treatment Model.)

Materials

General materials include snacks (e.g., chips, crackers, granola bars, fruit bars), drinks (e.g., milk, fruit juice, caffeine-free soda), chairs, and (if applicable) a videocamera and videotapes or audiorecorder and audiotapes.

Procedure-specific materials: none.

General Notes for the Therapist

A caregiver is not necessarily a parent. A caregiver could be an older sibling, a grandparent, or another adult who is willing to try to help the adolescent with recovery. It is usually someone who lives with the adolescent.

Caregivers may be emotional during the first session. They may be either angry or sad. Some will be very angry with their adolescent and want to talk about how "bad" the youth is. Others may feel a sense of failure that this has happened in their family. It will be important to listen empathically and then attempt to motivate them to play a positive role in their adolescent's treatment.

During the session, maintain a positive and enthusiastic tone of voice. Your demeanor can help build a positive atmosphere for change and motivate the caregiver to follow through with the four sessions.

Procedural Steps

1. Use rapport-building techniques.

2. Provide an overview of ACRA.

3. Motivate or "hook" the caregiver into continued work with the ACRA therapist.

4. Provide information to the caregiver about research findings on the most important parenting practices for keeping his or her adolescent from relapsing.

5. Assess whether problems appear serious enough to warrant other referrals.

6. Assign homework (but do not call it that).

7. Complete the *ACRA Procedure 9 Checklist—Caregiver Overview, Rapport Building, and Motivation* immediately after the session.

Detailed Description

The remainder of this section contains a more detailed overview for conducting the first session with the caregiver. Procedural steps are in **bold type** and are followed by further directions and comments.

1. Use rapport-building techniques.

Strategies for building rapport include:

- Let the caregiver have the opportunity to discuss his or her feelings about the family situation.

- Empathize with the caregiver's concerns. After doing so, begin to refocus on what needs to be done now, and shape the interaction in a positive way. (See below.)

- Reinforce that the caretaker must attend the sessions, and let him or her know that you understand it may be difficult to do so.

- Share general information from your work with other families, affirming that these sessions can be helpful and that research has shown that these techniques have helped other families in similar situations.

Techniques for keeping the discussion positive. These techniques from *Functional Family Therapy* (Alexander & Parsons, 1982; Waldron & Slesnick, 1998) can be helpful to therapists as they try to shape a positive discussion:

- **Relabel behavior.** Change the meaning and value of a negative behavior by describing positive properties of the behavior or by explaining that the adolescent is not engaging in it to make the parent or caregiver miserable or angry. If possible, suggest positive motives for the behavior, and/or portray family members as victims rather than perpetrators. For example, the adolescent may be described as someone who is struggling to become independent and is trying very hard to be accepted by friends. Relabeling behavior gives family members "another picture" or new information about behaviors and is most effective if it ascribes benign or benevolent motives.

- **Curtail blaming.** Communicate to the caregiver that blaming someone for previous problems does not serve any purpose. Emphasize the future, not what happened in the past.

- **Use a positive focus.** Emphasize family strengths by repeatedly reinforcing discussions about aspects of family life that are working well, such as pleasant events and family activities. For example, "Tell me something nice that your child has done during the 15 years he or she has been a part of your family."

- **Use exception statements.** Try exception statements, another technique useful in decreasing family blaming statements (Melidonis & Bry, 1995). To use this technique, ask the caregiver to describe a situation from the past in which the problem behavior was expected to occur but did not. Then probe into what was different about this situation.

2. **Provide an overview of ACRA.**

- Describe ACRA, including the success, philosophy, and the focus of ACRA therapy sessions.

- Provide information about the length of treatment sessions, the number and type of ACRA therapy sessions, confidentiality, urine testing, and videotaping or audiotaping, if appropriate.

- Praise the family for participating in treatment and try to make the members feel comfortable, stating something such as, "I am really glad you came to treatment; I look forward to working with you!"

- Encourage the family to ask questions, and let both the caregiver and the adolescent know that they can ask questions about therapy at any time during treatment.

- Describe the purposes of ACRA caregiver sessions. During the sessions you hope to (1) help diminish the caregiver's pain, (2) help improve communication, and (3) help improve the relationship between the caregiver and the adolescent.

3. Motivate or "hook" the caregiver into continued work with the ACRA therapist.

Set positive expectations and try the following procedures.

- Assess the caregiver's reinforcers related to the youth's stopping substance abuse, and use these to help motivate the caregiver to "try ACRA."

  Sometimes the caregiver's reinforcers are revealed through conversation, but usually it will take questioning to elicit them. Ask, "What benefits will result if the adolescent stops using?" Most caregivers will be able to articulate the benefits or goals for their adolescents. For example, they want their teenagers to graduate from high school and to avoid incarceration. Other caregivers' motivation revolves around themselves, such as wanting to make their own life easier. For example, a caregiver may say, "I want the school system off my back."

  Work with whatever reasons the caregivers offer for wanting their adolescents to stop using alcohol or marijuana, and try to help them see how the therapist, caregiver, and teen can work together to achieve their goals.

- Reiterate potential benefits of ACRA discussed during the overview; emphasize that caregiver involvement in treatment could help improve the relationship between the caregiver and his or her teenager and could help lead to more success in life for the teenager.

- If the caregiver is skeptical because of past treatment failure or because he or she does not believe that the adolescent will quit using alcohol or drugs, emphasize that recovery is a process. Tell

the caregiver that you believe this program can work for him or her. Try to get commitment to attend at least four ACRA sessions. You might say something like, "I know you love your son (daughter). Sometimes parents just don't know what to do when there are problems with their children, and sometimes it is helpful to try different things."

4. **Provide information to the caregiver about research findings on the most important parenting practices for keeping his or her adolescent from relapsing** (based on the work of Catalano [1998], Hops [1998], and Bry [1998]).

According to Catalano, Hops, and Bry, the following are four critical practices that parents or caregivers can adopt to help their children remain abstinent:

- The single most important parenting practice is for caregivers to be good role models by refraining from using drugs or alcohol in front of their teenagers. When discussing this with caregivers, tell them that you are not "accusing them of using" but that they need to know this. Ask them whether they will agree not to use substances in front of their teenager.

- A second critical parenting practice is to increase positive communication with their adolescent. Parents or caregivers should strive toward decreasing blaming and "put downs" and increasing positive talk with and about their teenagers. Explain that in the next session, you will work with them on communication skills.

- A third important parenting practice is to monitor the adolescent's whereabouts, including knowing where they are and whom they are with.

- A fourth critical parenting practice is involvement in the adolescent's life outside the home by encouraging and promoting prosocial activities.

It is important to maintain a dialog during the session, so it is helpful to weave a discussion of the four parenting practices into conversation. For example, you may ask, "What are some of the things you do really well as a caregiver?" or "What are some things you do to keep your teenager away from alcohol or drugs?" As you review the caregivers' responses, look for opportunities to praise them for positive parenting practices.

During a discussion of the four practices, caregivers may bring up issues or problems. If so, you can begin to talk to the caregivers about their issue of concern but still try to review all four parenting practices. For example, a parent may say he or she has a problem showing appreciation for his or her teen. You may help him or her practice providing praise or showing appreciation. Or the caregiver may reveal he or she rarely encourages the

teen to attend positive social activities. You may begin helping the caregiver identify positive social activities.

The caregiver's primary role with regard to developing other community reinforcers is to help the adolescent access them or support his or her interest in them by spending time with the adolescent as he or she watches or participates in the activities.

5. Assess whether problems appear serious enough to warrant other referrals.

It is especially important to make referrals if there are other adults or adolescents in the home who are presently involved in substance abuse or who have serious mental health problems. You should report any instances of possible abuse.

6. Assign homework.

At the end of the discussion, try to get the caregiver to commit to homework such as providing praise, appreciation, and positive reinforcement to the teenager at home. You may introduce the assignment this way, "We've found that the best way to have these new behaviors become part of your normal behavior is to practice them. Would you be willing to try them a couple of times before I see you again?" (If the answer is yes, help specify what he or she would do.) Examples of homework might be to praise the teenager at least twice a day and locate a positive activity and encourage the adolescent's participation in it. At the next session, review the caregiver's success with the homework tasks. You also should review the four critical parenting practices to help reinforce these concepts.

7. Complete the *ACRA Procedure 9 Checklist—Caregiver Overview, Rapport Building, and Motivation* immediately after the session.

A blank copy of this form is included at the end of this section.

Date_____ Session #_____ Adolescent ID_____ Therapist Init._____

ACRA Procedure 9 Checklist—
Caregiver Overview, Rapport Building, and Motivation

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you maintain a positive and enthusiastic tone of voice?			
2. Did you employ rapport-building techniques with the caregiver?			
3. To keep the discussion positive, did you relabel behavior?			
4. To keep the discussion positive, did you curtail blaming?			
5. To keep the discussion positive, did you constantly reinforce discussion about aspects of family life that are working well and pleasant events and family activities?			
6. Were you able to motivate or "hook" the caregiver into continued work?			
7. Did you talk about the benefits of ACRA?			
8. Did you provide information to the caregiver about what he or she can do to keep the adolescent from relapsing?			
9. Did you assess whether the problem appears serious enough to warrant another referral?			
10. Did you get the parent or caregiver to commit to some homework (without calling it homework)?			

Procedure 10: Caregiver Communication Skills Training

Rationale

Caregivers and adolescents often have a difficult time communicating in a positive, effective manner. It is not unusual for caregivers to be frustrated with their adolescents' behavior in a number of areas, and substance abuse problems can exacerbate an already troubled relationship. Improving communication skills can help family members develop more positive relationships.

Purpose of the Procedure and Learning Objectives

The purpose of this session is to improve the communication skills of the caregiver. The caregiver will learn the importance of good communication skills in improving relationships; how to use the ACRA communication techniques such as understanding statements, a partial responsibility statement, and offer-to-help statements; and how to use these techniques in real life situations.

Timing, Audience, and Delivery Method

This session is conducted individually with the caretaker in weeks 3 to 5 of treatment. The caregiver has the opportunity to practice these skills during the session and is asked to continue practicing them before the next session. In a later session, the caregiver and adolescent are brought together for joint practice.

Materials

General materials include snacks (e.g., chips, crackers, granola bars, fruit bars), drinks (e.g., milk, fruit juice, caffeine-free soda), chairs, and (if applicable) a videocamera and videotapes an audiorecorder and audiotapes.

Procedure-specific materials include clipboard; chalkboard or whiteboard; pens, markers, or chalk; and an easel for presentation of material on communications skills.

General Notes for the Therapist

The skills outlined in this section are taught within the context of real communication problems between the caregiver and adolescent. Although the therapist "teaches" the caregiver about effective communication skills, the teaching is grounded in the experiences of the caregiver. The caregiver is not merely a passive recipient of the learning that takes place but is actively involved. This approach helps make the procedures more valuable to the caregiver, who will then be more likely to try them in real life.

The skills covered in this section can be used to enhance communication with other people besides the adolescent.

Procedural Steps

1. Introduce the topic of communication, and provide a rationale for developing good communication skills.

2. Assess and talk about the present quality of communication between the caregiver and adolescent.

3. Using real life examples provided by the caregiver, teach the caregiver ACRA communication techniques.

4. Roleplay a number of interchanges between the caregiver and adolescent, with the therapist taking the role of the adolescent. Insert ACRA and general communication techniques whenever helpful, and mention pitfalls to avoid. Then switch roles with the caregiver playing the adolescent and the therapist playing the caregiver.

5. Process each exchange from the content and feelings perspectives of the caregiver.

6. Assign homework.

7. Complete the *ACRA Procedure 10 Checklist—Caregiver Communication Skills Training* immediately after the session.

Detailed Description

The remainder of this section contains a step-by-step description for providing communication skills training for caregivers. Procedural steps are in **bold type**, and they are followed by further directions and comments. Sample dialogs between a therapist and caregiver are indicated in *italic type*.

1. Introduce the topic of communication, and provide a rationale for developing good communication skills.

Take a few minutes to introduce the session, and talk about why it is important to focus on communication skills. Find out what reinforcers would motivate the caregiver to make changes in his or her behavior. For example, a caregiver might say, "I'm really tired of all the arguing." Key points to make include the following:

- Communication between the caregiver and the teenager can be difficult, especially when the teen has difficulty with substance abuse.

- The fact that you want to discuss communication skills does not mean that you think the caregiver does not know how to communicate. However, most caregivers would probably agree that they could use some guidelines to help them when communication becomes difficult or awkward, such as when they try to solve a problem or talk about a difficult situation with their teenagers.

2. Assess and talk about the present quality of communication between the caregiver and adolescent.

Ask the caregiver about the quality of communication when trying to talk with the adolescent about (1) nonproblem topics (social or typical everyday-type conversation) and (2) problem topics (the teenager's substance use, a problem at school, or a problem at home). How do things tend to go? Has there been any good communication in the last 2 years? Ask the caregiver for examples of real life conversations discussing both a nonproblem and a problem situation.

Therapist: *Tell me what happens when you try to talk together about. . . .*

For those situations that do not go well (e.g., caregiver or teenager gets angry or frustrated and leaves, or the caregiver and teen get into a fight), listen and observe carefully to understand the dynamics that typically unfold between them. To make sure you understand the situation (and to show the caregiver you are listening), you may want to repeat the situation to the caregiver and ask clarifying questions.

Therapist: *Let me see whether I understand this. Gina typically comes home after curfew 2 or 3 nights per week. She walks in, and you stand there and say, "You're late." She responds, "Tough," and walks to her room. Her response makes you angry, and you lose your temper and say things like, "You can move out when you're 18 if you can't follow the rules" and "Go live with your father; you can be his problem." She typically locks herself in her room and says nothing back to you. She just shuts down, puts on the radio, calls a friend on the phone, and shuts you out completely. Is that accurate? What do you do after that?*

Ask the caregiver how satisfactory the quality of communication is with the adolescent. If the caregiver is unhappy with it, ask what he or she would like to have happen. Listen carefully to try to understand the caregiver's goals.

Assure the caregiver that you will teach a few techniques that may help with the communication problems. You will also roleplay a few situations with the caregiver to give him or her a chance to practice before he or she encounters a real problem situation with his or her teenager. A goal is to get the teenager and caregiver to make decisions together. If both persons are involved in developing a solution to a problem, they are more likely to follow the agreed-on steps to the solution.

3. Using real life examples provided by the caregiver, teach the caregiver ACRA communication techniques.

ACRA has three basic parts to effective communication: (1) giving an **understanding statement**, (2) taking partial responsibility, and (3) offering to help. An understanding statement brings feelings into the conversation—in particular, empathy. It shows that one person is capable of seeing things from the other person's perspective. The caregiver can also try to help the teenager understand the caregiver's perspective. The effect on the other person is a feeling of validation, and this will decrease defensiveness. A **partial responsibility statement** indicates that the caregiver is willing to accept a role in creating or solving a specific problem. It does not mean the caregiver or anyone else is to blame or that it is all up to the caregiver to solve the problem. It acknowledges that the caregiver has a shared responsibility with the adolescent for creating and solving a problem. An **offer to help** is just that—an offer by the caregiver to help solve the problem. In this instance, the caregiver tries to think of ways that would make it easier for the teenager to cooperate. In some cases, it may be necessary to set up a contingency—that is, the teenager is able to do something he or she wishes if he or she follows through with an agreed-on behavior.

Taken together, these three communication skills deliver the message that the caregiver wants a change in the teenager's behavior but that the caregiver is willing to be actively involved and supportive in the process. The outcome is decreased defensiveness on the part of the adolescent and more open lines of communication.

Using a problem situation between the caregiver and adolescent, introduce each of the three ACRA communication techniques where they would be helpful. The techniques are generic so they can be used in virtually any problem situation. For example:

Therapist: *Okay, Mrs. Smith, let's go back to that situation between you and Gina when she comes home late. Let's replay that conversation, break it down into pieces, and try to understand where you are coming from at each point and how you and Gina feel. As we go through the conversation, I'd like to offer three*

techniques that will help the conversation stay calm and be more productive. The first technique is to try to make an understanding statement. An understanding statement brings empathy into the conversation and helps decrease defensiveness because you are really trying to understand the other's perspective. So what do you think Gina's perspective is on this issue?

Caregiver: *I mean, I guess I can understand that she enjoys running around with her friends and is reluctant to come home if they are out having a good time. And we have been fighting a lot lately.*

Therapist: *That's a great start. Talk to me as if I'm her, using an understanding statement.*

Caregiver: *Gina, I understand that it is hard to leave your friends to come home when you are having a good time. I also understand that you may not enjoy being at home because we have been arguing a lot lately.*

Therapist: *That was perfect! Now the next component is to try to take partial responsibility for the problem or solution.*

Caregiver: *How is it my fault?*

Therapist: *This technique is not to place blame on anyone. It is meant to indicate that you are willing to accept a role in creating or solving the problem.*

Caregiver: *One thing that I am probably guilty of is not hearing the reasons why she is late, encouraging her to call, or even sitting down to talk to her about solutions to this problem. I just instantly start yelling, then I get so angry at her response that I say hurtful things to her—like she can move out when she's 18 or can go live with her father and be his problem. That isn't right. That really bothers me.*

Therapist: *Have you ever shared these feelings with Gina?*

Caregiver: *No. That's the problem. We can't just sit down and talk without fighting.*

Therapist: *You have been doing great in here with me. Maybe by going over some of these helpful techniques you will be able to sit down and talk. So talk to me using the understanding statement and the partial responsibility component.*

Caregiver: *Okay. Gina, I understand that it is hard for you to come home on time when you are having a good time with your friends and to come home to us always arguing. You just get me so angry that I start yelling and. . . .*

Therapist: *You are doing well, but try to use "I" statements. Instead of saying you just make me angry, start by saying I feel angry when. . . . Good job on the understanding statement. Start with the partial responsibility again.*

Caregiver: *I want to apologize for how I act at times. I get angry when you are not home when you are supposed to be. I feel like you don't respect me. I get so worried. When I get worried or angry, I start yelling and say things that I don't mean. I would like to change and try to improve our relationship by trying to improve the way we talk to each other. I would like to hear what you think or what you think we can do together to help.*

Therapist: *Great. You are doing very well. Now the third component is the offer to help. It is an offer on your part to help solve the problem. Can you think of something you can offer to do to help resolve the issue of Gina's breaking curfew?*

Caregiver: *I could offer to give her transportation, be open to having her call me if she is going to be late, or discuss the reasons why she has been breaking curfew.*

Therapist: *Now let's review the three components by having you talk to me as if I'm Gina, using all of them together.*

Caregiver: *Gina, I understand that it is hard for you to come home on time when you are having a good time with your friends and you come home to us always arguing. I want to apologize for how I act sometimes. I get worried when you are not home when you are supposed to be. When I get worried or angry, I start yelling and say things to you that are hurtful and that I don't mean. I am really sorry. I would like to try to improve our relationship by trying to work on how we talk to each other. I would be open to talking about how you feel about curfew and some of the reasons why you have been breaking it and to seeing if we can come up with some ideas together to solve our problem.*

Therapist: *Fantastic! How did it feel using these techniques?*

Caregiver: *Weird at first because I really have to think about what I am saying. I just hope I can do it.*

Therapist: *You're off to a good start. If you get angry, you might try to walk away or take a deep breath then try to use these techniques. Because when you are angry, you say things to her that you don't mean. This week would you be willing to try to use these techniques when talking with Gina?*

Caregiver: *I'll try.*

Therapist: *How do you think Gina will respond if you try talking to her using these techniques?*

Caregiver: *She will probably think I am crazy, but I really want our relationship and communication to improve. So, I'm willing to give it a shot.*

Therapist: *Good. I like your openness to trying new things. I will be going over these techniques with Gina as well. So she might be trying these techniques at home too. Later, when we all meet together, we will be using these techniques in our family sessions together.*

The therapist might have the caregiver practice several different versions of this roleplay. The purpose of the exercise is to practice and to give the therapist an opportunity to help shape the skills being taught. Roles can be switched; the caregiver can play the adolescent, and the therapist can play the caregiver. This is helpful for a number of reasons. It helps the caregiver understand the adolescent's point of view, and it gives the therapist a chance to demonstrate or model the techniques. Assign homework to practice the skills outside the session. During the next session, review any practice attempts and their outcomes.

4. **Roleplay a number of exchanges between the caregiver and adolescent, with the therapist taking the role of the adolescent. Insert ACRA and general communication techniques whenever helpful, and mention pitfalls to avoid. Then switch roles with the caregiver playing the adolescent and the therapist playing the caregiver.**

After completing an initial roleplay and providing feedback about how to improve the effectiveness, practice again. Ask the caregiver for another example of a problem situation. Dissect the problem and help the caregiver reword the conversation using effective communication techniques. Both general communication techniques (e.g., use of "I" statements rather than "you" statements, active listening) and those in ACRA should be introduced wherever they can help.

Encourage the caregiver to roleplay with you conversations with his or her adolescent. Although roleplaying can be awkward for some people, encourage the caregiver to participate fully. One way to reduce the awkwardness might be to avoid using the word "roleplay." Instead, you can say something like,

"Okay . . . let's just pretend I'm [insert the name of the adolescent], and let's practice some of the techniques we were just discussing." Whenever needed, the caregiver can leave the role to ask questions or for advice. The caregiver should have the experience of playing both roles—that of the caregiver and that of the teenager. Point out any examples of barriers to communication (e.g., blaming or bringing up old problems) and explain how they will negatively affect communication.

5. Process each exchange from the content and feelings perspectives of the caregiver.

Following each roleplay, discuss it with the caregiver. Questions to ask are, How did it go? What was different about the conversation compared to how a typical one goes? How did it feel for you to play the role of the teenager? Processing the roleplay is essential to solidify learning. A followup question for the caregiver is, How do you think your teenager would respond to this style of communicating?

6. Assign homework.

At the end of the session, assign practicing communication techniques as homework. It is important to get a commitment from the caregiver to try these skills at home. During the next session, review the results of these attempts.

7. Complete the *ACRA Procedure 10 Checklist—Caregiver Communication Skills Training* immediately after the session.

A blank copy of this form is included at the end of this section.

Date_____ Session #_____ Adolescent ID____ Therapist Init._____

ACRA Procedure 10 Checklist—
Caregiver Communication Skills Training

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you introduce the topic of communication, providing a rationale for developing good skills in this area?			
2. Did you assess the present quality of communication between the caregiver and the adolescent?			
3. In the context of real life examples provided by the caregiver, did you teach the caregiver to give an understanding statement?			
4. In the context of real life examples provided by the caregiver, did you teach the caregiver to make a partial responsibility statement?			
5. In the context of real life examples provided by the caregiver, did you teach the caregiver to offer to help the adolescent solve the problem?			
6. Did you roleplay exchanges between the caregiver and the adolescent and insert ACRA and general communication techniques whenever helpful?			
7. Did you point out any problems (e.g., blaming and bringing up old issues)?			
8. Did you switch roles with the caregiver?			
9. Did you process each exchange with the caregiver, from the content and feelings perspective?			
10. Did you get the caregiver to commit to doing some homework?			

Procedure 11: Caregiver–Adolescent Relationship Skills

Rationale

In previous sessions, both the adolescent and caregiver reviewed and roleplayed positive communication skills. The adolescent also has learned techniques for problem solving. Problem-solving training can help caregivers and adolescents find more satisfactory solutions to their problems. These procedures are for use in two sessions to provide ample opportunity for the caregiver and the adolescent to practice these skills together with the therapist's guidance.

Purpose of the Procedure and Learning Objectives

The main purpose of this procedure is to **improve communication** between the caregiver and the adolescent. The learning objectives are to help both parties improve their ability to:

- Use **problem-solving skills** introduced in previous sessions
- Say **positive** things about each other
- Speak "nicer" to each other.

Timing, Audience, and Delivery Method

The next two sessions are held with the caregiver and the adolescent together, in weeks 7 to 11 of treatment. By this time, there should have been two sessions with the caregiver and enough time to establish rapport and a working relationship with the adolescent.

Materials

General materials include snacks (e.g., chips, crackers, granola bars, fruit bars), drinks (e.g., milk, fruit juice, caffeine-free soda), chairs, and (if applicable) a videocamera and videotapes and an audiorecorder or audiotapes.

Procedure-specific materials include:

- Handout: *Relationship Happiness Scale* (caregiver and adolescent versions), clipboards, and pens
- For problem solving: chalkboard or whiteboard, markers or chalk, and possibly an easel.
- For communication skills: chalkboard or whiteboard, markers or chalk, possibly an easel, the handout *Daily Reminder To Be Nice*.

General Notes for the Therapist

Emphasize to the caregiver and the adolescent that during these sessions the focus is on the positive attributes of the other person. Guide them to face and talk to each other during roleplays because the goal is to improve communication between them. They may try to talk through you because they feel awkward in the session or because of their poor communication history. You can help maintain rapport with both by periodically asking how they are doing during the session.

It is important for you to maintain an equal amount of eye contact with both during this session and to avoid siding with one person over the other. Remember to encourage the caregiver and teenager to talk with *each other*. Also, in the beginning emphasize keeping the conversation positive. Discourage any blaming. You can assist by interpreting, coaching, modeling, and shaping as needed.

Shaping is an important principle of operant conditioning (behavior modification). It involves reinforcing (e.g., through praise, tangible rewards) **small steps** toward achieving a larger goal. It is particularly useful when mastery of a series of small skills, steps, or procedures is necessary to achieve a complex goal. For example, in trying to teach problem-solving skills, the therapist should not criticize poor solutions or tell clients to choose more effective solutions. Instead, the therapist should use a shaping process that breaks effective problem solving into small components or steps. Mastery of each component is shaped through teaching, modeling, rehearsal, feedback, and praise. As clients master each component, they learn the skills necessary to solve problems. Once they have mastered all the steps needed to complete a task, they have completed the skill acquisition and should be able to use the problem-solving procedure to effectively solve their problems.

Procedural Steps

1. Thank both the adolescent and the caregiver for coming in, praise their work, and offer snacks and beverages.

2. Provide an overview of what is going to happen during the session. Be clear from the beginning that the emphasis is on being positive during the session.

3. Check to see whether there are issues that have arisen since the last session.

4. Have each person face the other and say **three positive things** about the other person.

5. Review **communication skill procedures** with both parties. (See procedures 6 and 10.)

6. Review **problem-solving skill procedures** with both parties. (See procedure 7.) This will be the first time that caregivers are introduced to these skills.

7. Have both participants complete the *Relationship Happiness Scale* forms. (As you review the completed happiness scales, you may discover issues for roleplaying communication and problem-solving skills.)

8. Have the caregiver and adolescent generate realistic **roleplay** situations to practice communication and problem-solving skills.

9. Assign homework.

10. When time permits (it may not be until the second session), present information on the *Daily Reminder To Be Nice* form.

11. Spend a little time on closure with the caregiver. Remind the caregiver that this will be the last session with him or her, review what was covered in previous sessions and how it went, and thank him or her for participating.

12. Complete the *ACRA Procedure 11 Checklist—Caregiver–Adolescent Relationship Skills* immediately after the session.

Detailed Description

The remainder of this section contains a more detailed overview on how to conduct the two sessions on reinforcing and practicing caregiver-adolescent relationship skills. Procedural steps are in **bold type** and are followed by further directions and comments. Sample dialogs between a therapist and the caregiver and adolescent are indicated in *italic type*.

1. Thank both the adolescent and caregiver for coming in, praise their work, and offer snacks and beverages.

As in every other session, praise both parties for meeting with you and reinforce their work in treatment. The verbal reinforcers and snacks all serve to continue engaging the caregiver and teenager in treatment.

2. Provide an overview of what is going to happen during the session activities. Be clear from the beginning that the emphasis is on being positive during the session.

To alleviate any anxiety on the parts of the caregiver and teenager, provide an overview of the content of the session. Explain that you will (1) review communication skills, (2) review problem-solving techniques, and (3) have both complete *Relationship Happiness Scale* forms. Note that when going through problem solving, the emphasis will be on finding a solution that works for everyone—a win-win solution.

Therapist: *I want to talk with you about what we are going to be doing today. We're going to be reviewing communication skills that I have already gone over with each of you. Then we are going to go over some problem-solving techniques. I've gone over these with Erica before. Then after that, we will go over something that Erica has done before that is called the Relationship Happiness Scale. This one is a little different from the ones we have done before because this time we will be looking at how happy you are with your relationship with the other person.*

3. Check to see whether there are issues that have arisen since the last session.

Check with the teenager to see whether he or she has any pressing issues. Acknowledge any issues that are mentioned, but try to steer the teenager and caregiver to the session topics. One way to do this is to say, "That is a really important issue, and I want to spend some time talking about that. There are some other things we want to cover first, though." Here is an example of how this part might go:

Therapist: [Looks at the adolescent.] *First, I need to check to see that everything's okay.*

Adolescent: *I got suspended from school because I left campus during a study hall. I thought that it was okay because I had finished my exams for the day.*

Caregiver: *The principal called me and said she wasn't the only one who got suspended. A lot of the students did the same thing and a lot got suspended.*

Therapist: *Well, we should look at that and some options that could prevent that kind of thing next time. Maybe we will be able to look at that this session; we want to talk about some things that affect both of you and maybe this one did.*

4. Have each person face the other and say three positive things about the other person.

Positive comments about the other person set the tone for the session. Have each person use "I" statements when stating the positive comments. For example, "I appreciate that you are always home when I get home from school" or "I think it is neat that you know so much about computers." Periodically ask the person on the receiving end to repeat back what he or she heard the other person saying. This ensures that the person hears the good things that are being said and helps develop listening skills.

Therapist: *I'd like to keep things on a positive note—you never know what can come out, so let's start by each of you sharing with the other person three things you really appreciate about each other. I'd like for each of you to go ahead and face each other and tell the other person what you appreciate about her. Mrs. Smith would you begin. Go ahead and face Erica.*

Caregiver: *I really, really appreciate it—your attitude, 'cuz I see a lot of teens get an attitude. You never have done that. When you go out, you've never been late, no more than 10 minutes. These are two really important things. I don't worry as much. I try to tell you in certain ways and maybe it doesn't come out and you don't hear what I try to tell you.*

Therapist: *Erica, what do you hear your mom saying?*

Adolescent: *Well, it sounds like she's glad that I don't smart talk her and that I come in on time.*

Caregiver: *Yes, that's right, because I worry so much about . . . car accidents. If a car doesn't pull up on time, that is the first thing I think of.*

Therapist: *Sounds as if you see Erica as a really responsible person. That's great. Erica, do you want to share some things you appreciate about your mom.*

Adolescent: *I appreciate the fact that she like . . . if I need to talk her, she'll be there. Sometimes she gets on my nerves when she comes to my room, but sometimes I really, really need to talk to someone and she's there.*

I appreciate the fact that she puts up with my girlfriends.

I appreciate the fact that she's here with me now. I don't know how it is helping, but it is.

Therapist: *Erica, you did a great job coming up with positive comments. You were telling me though, not your mother. Can you turn and face your mom and tell her those nice things?*

[Erica turns to her mom and directs her comments to her.]

Caregiver: *I think we find it easier when we come here to tell each other that we care about each other. I'd like to throw one more in. I appreciate the fact that you're* [directed at daughter] *coming here.*

5. Review communication skill procedures with both parties. (See procedures 6 and 10.)

Because both parties have had this training before, try to get them to remember the three techniques for improved communication. Have a white board available to write down the techniques as they mention them.

Therapist: *Very good. You both did a very good job with coming up with things you appreciate about each other and sharing them.*

Now, let's review communication skills. Okay, who wants to tell me one of the three techniques we use to help with communication?

[Erica gets up out of her chair and goes to the board; she wants to write on the board. Erica and Mrs. Smith have difficulty coming up with the three techniques, although they throw out related concepts like "active listening" or "staying positive." The therapist reinforces their attempts and then tells them the name of the first technique.]

Therapist: *The first is an understanding statement.* [The therapist gives an example.]

The second one is called taking partial responsibility. It's acknowledging how you might have contributed to the problem. For example, saying, "You know, I realize I didn't give you a lot of time to do dishes" or "I realize that you didn't have time to hang out with your friends." So it is saying how you might be a part of the problem—or just making a statement that shows you don't blame the other person. Mrs. Smith, go ahead and take a shot at that partial responsibility statement. Remember that you are more likely to get what you want if you use one.

[Next they talk about an offer to help.]

Therapist: *A new technique I want to tell you about is called "avoiding a no" in a response. What I'd like you to try is negotiating without saying a flat out "No!" Let's say Erica wants to do something on Friday, but you're concerned about what she might get involved with while she's out. A good solution is not always perfect for everyone, but sometimes you can get closer to what both people want . . . and the main thing is happiness in the relationship, right?* [Looks at her mom.] *There are probably times when Erica is driving you crazy, but still you want to have happiness in your relationship.*

You want to be able to come to a solution together that works for both of you.

6. **Review problem-solving skill procedures with both parties. (See procedure 7.) This will be the first time that caregivers are introduced to these skills.**

Ask the teenager to explain the steps because he or she has already been oriented to and practiced these skills. When practicing problem solving, both the caregiver and the teenager can brainstorm. Then they each get a turn to cross out suggestions, which are often the other person's. Then they work toward agreeing on a solution. If they end up crossing off all the solutions, then both have to start over. Eventually they will see that they have to work together; otherwise, they will have to be continually generating more possible solutions.

7. **Have both parties complete the *Relationship Happiness Scale* form. (As you review the completed happiness scales, you may discover issues for roleplaying communication and problem-solving skills.)**

This is also a good procedure to have teenagers help explain because by this session they have filled out several happiness scales. Because the adolescent scale is different from the adult scale, provide an initial orientation to the scales. After both the caregiver and the teen have filled out a form, begin by reviewing those items that each rated high to continue emphasizing positive interactions. For example say, "What are some things that are going well with____?"

Therapist: *Erica, you've filled out happiness scales a lot before. But these are somewhat different from what you have filled out. We call these "Relationship Happiness Scales" because we want you to rate your happiness with your relationship with each other in different areas. Erica, you will notice that the areas are different on this happiness scale, too. So, would you be willing to read the directions to us and then explain them in your own words?*

Adolescent: *Sure.* [Erica reads the directions on one of the forms.] *Basically, it means if you are really happy with what I do in that area, you circle a 10 and if really unhappy, then circle a 1.*

Therapist: *Good job. Another important thing to remember is that this is for right now. It is what you see right now. Go ahead and fill it out and put your name at the top. Then give them to me because I want to look them over before we start talking about them.*

[Both complete the forms.]

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In general, there are some things that you rate really high and there are some things that you rate low. Let's talk about what things are good in the relationship. It's important to learn what we are doing well, so we can keep that going.

[Looks at Erica] *You rated allowance really high. Could you explain why you rated allowance so high?*

Adolescent: *I didn't used to get allowance. I get $20 a week for doing the dishes.*

Therapist: *I see that you* [looks at the mother] *rated "affection" very high. Could you explain your rating?*

Caregiver: *When I go to her room and say good night and give her a kiss and a hug, Erica always responds and she always tells me that she loves me before I even say it.*

Adolescent: *She always comes to my room to give me a kiss and hug. If I'm feeling bad, she gives me a kiss and a hug.*

Therapist: *Let's see. Looking at this—one thing that there might be an issue with is communication. Where do you see some positives first of all?*

Adolescent: *One thing that I really noticed big time is that she came upstairs and told me that she was suspended from school. She came up and told me this is what happened. I appreciated the honesty.*

Therapist: [Looks at Erica] *What is something positive you like about talking with your mom?*

Adolescent: *If I come up to her and talk to her, she listens and stuff. Usually most of the time if I do something and it's not that big of a deal, instead of yelling at me, she'll be like, what are you going to do to take care of this problem now?*

8. Have the caregiver and adolescent generate realistic roleplay situations to practice communication and problem-solving skills.

It is very important to use roleplaying as part of the training. It may be necessary to first work on asking for things and remaining positive. The caregiver and adolescent should not only talk about how they would communicate better or solve problems better; they need to try the techniques. When they do so with you present, you can help model and shape the behaviors.

Therapist: *Tell me something that you would like to work on about communication.*

Caregiver: *There is only one thing that I have a problem with . . . that is on the school issue. It is the importance of education. I end up getting frustrated. I want her to understand about education. When it comes to talking about this with me, the word "bunk" is used a lot.*

Therapist: *What you are telling me is that education is important and you'd like to be able to express that to Erica a little better so that she sees your point a little more.* [Provides example of a good reflective statement.] *How do you see this, Erica?*

Adolescent: *About school . . .*

Therapist: *Yeah—actually school and communication about school.*

Adolescent: *With the school thing . . . I think that school is important. I don't show it that much. It is important because I'm going to go to a trade school. I just think about school at school and then when I get home, I just don't want to think about it.*

Therapist: *Okay, so it is important because you want to go on to trade school. But at the same time you want to leave school at school. You, on the other hand,* [turns to parent] *you'd like . . .*

Caregiver: *Maybe it's my wording. There have been several subjects that she has problems with. When I've talked to Erica about this . . . I try to tell her that she needs to let someone know about that. I'd help . . . ask someone or get a tutor. I know it's important because I used to work in offices but now I'm working in a laundry room because I don't have the office skills they need now. I worry about her future. Is she going to go to college? If not, what kind of work is she going to do?*

Therapist: *One of your goals is for her to finish up high school and then go to college or trade school.*

Caregiver: *Yes, because it is hard to make it.*

Therapist: *Mom, use the communication skills now when you talk to Erica. Just try it. Maybe you can only do it partially, but that's fine. If you practice it, then when you really need it, you will be able to use these skills. Let's go ahead and try out the communication skills.*

[Therapist models what needs to be said.] *"Erica, I understand that you like your free time after school and don't want to think about school work; but I worry about the type of job you would get if you don't finish school because I want things to work out for you. I would really appreciate it if you would bring your school work home so you can graduate from high school. I know that I haven't always stressed education and I myself haven't gone far in school. If there is anything I can do to help you get to school or bring your school work home or anything we can do to find a particular trade, I would be willing to help." Your job is not to say something directive like, "You have to finish up so you can go to college."*

Caregiver: *I can see a big mistake that I am making. Basically I'm not doing the understanding statement.*

Therapist: *Erica, can you break down what I just said and tell us which was the understanding statement, what did I say for partial responsibility, and what did I say that was an offer to help?*

[This is important to ensure that they both are able to identify the three skills. Erica does this.]

Go ahead and make an understanding statement. [The therapist tells the mother to face the adolescent and encourages her to direct her statement to her and not to the therapist.]

Caregiver: *I understand that it is hard to sit in study hall for 2 hours; you're bored and you've already taken your finals. I'm concerned that since you're suspended now, you won't be able to make up your school work and that at the end of the school year you won't get your credits and graduate on time. If there is anything I can do to help—get you a tutor or if I can help—I'll make the time to help.*

Therapist: *That was good. Erica, how did it feel being spoken to this way by your mother, instead of the old way?*

Adolescent: *I liked it. My problem with the way you usually talk to me is that you blow up.*

Caregiver: *I think I get angry when I get worried for her. I'm projecting ahead about what is going to happen. If you miss so many classes or get suspended, you might not be able to finish school.*

Therapist: *I think you did some really good things when you were practicing now. With the understanding statement you showed you knew where she was coming from. You finished up with some good offers to help.* [Turns to Erica.] *Now why don't you try to use the communication skills.* [Praises the participants for any attempt that they make by trying to find something that they said that is on the right track. Remember, it is a shaping process.]

Adolescent: *I understand what you think about school being important and stuff. I would like for you to ask me every single night if I have algebra or American history homework and, if I do, make me do the homework because those are the subjects I have trouble with.*

Therapist: *Is that an issue? That you have trouble getting your homework done?*

Adolescent: *Yes, I have a problem keeping up with my homework.*

Therapist: *Okay, we are in problem solving here.* [Therapist stands up and writes on board.] *Let's start brainstorming about possible solutions. Erica, do you have any ideas?*

Adolescent: *Like I said . . . one thing mom could do is remind me about school work; another option is for me to bring home algebra and American history books each day.*

Therapist: *How about you, mom? Is there anything you could suggest?*

Caregiver: *If she needs a tutor, we can get her a tutor.*

Therapist: *Okay, let's just generate a bunch of ideas.*

Caregiver: *Or if she needs to read to me or have me ask her questions.*

Therapist: *So you could quiz her? Something I can think of that might help is to have a friend over to study.*

Adolescent: [Names two friends who are good at math.]

Therapist: *Are there any other suggestions?*

Both Clients: *No.*

Therapist: *First of all, without saying why, look at these possible solutions and tell us—are there any you don't want to*

do or don't think you would do? [Allows mother and Erica to cross suggestions off the list.]

Adolescent: *I don't think I'd do the tutor thing. I know I can do it . . . if someone tells me how I can do it. I know I'm smart. I've had a relapse in my smartness. My smartness is coming back.*

Caregiver: *I see a different Erica in the last couple of weeks. I see more confidence.*

Therapist: *Mom, is there anything on the list you don't want?*

Caregiver: *I can help her with American history, but not with the algebra—I stank at that.*

Therapist: *What is something that you can work on . . . what is a really good solution?*

Adolescent: *The really good one is to remind me about the homework and make sure that I do it.*

Therapist: *Anything you think would help?* [Directs question to the mother.]

Caregiver: *Have her friend over to study . . . because she has a friend down the street who she says is good at math.*

Therapist: *Is there anything you can do to make it easier?* [to Erica]

Adolescent: *I can keep my books in my book bag.*

Therapist: *Is there anything important for you about reminding her about homework?*

Caregiver: *Just to remember. I get home at 3:00 every day so I am there when she gets home from school.*

Therapist: *You guys did really well, and remember you did it together. I just wrote things down. But you had to come to a consensus on something you worked on together. You are willing to do something about school, but it is a matter of remembering.* [Therapist has the parent practice using her new communication skills and asks Erica to give feedback on which ways of reminding her. Earlier Erica said that she did not want want her mom talking about school, so this may be a tricky interaction.]

Therapist: *We're getting a little short on time. One thing I want to do is thank you for your work. Also, remember I'm not going to let you off. We are going to have another session when we can talk about how things went and how you used the skills on your own. You guys came up with some really good solutions. Keep in mind that you also did a really good job using the communication skills.*

Caregiver: *You know what is hard for me with these communication skills? I grew up in the old school. You asked a question and it was "Yes" or "No." The younger generation has this stuff in schools. It is really hard to communicate this way.*

Therapist: *The main thing to look at is whether you are getting what you want. You won't always get it, but you are more likely to get what you want if you are both working together.*

9. Assign homework.

At the end of the session, ask the family members to work on the possible solutions to the problem identified during the session. Then at the next session, review how the solution worked in practice, and, if problems have arisen, again use the communication skills and problem-solving procedures to address them.

10. When time permits, present information on the *Daily Reminder To Be Nice* form.

Because of lack of time, this procedure is usually introduced in the second session with both the caregiver and adolescent. All relationships are more pleasant when both parties work at being "nice" to each other. Acknowledge that for many parents or caregivers and teenagers there is a tendency not to be nice to each other. There are some types of behaviors that people can practice daily to help increase the number of pleasant exchanges, and these can be used with all family members. Following this section is a form that can be used to help prompt daily reminders to be nice in several areas. The following is a review of areas listed on the form with examples of each when needed. Work with the teenager and caregiver to generate additional examples for each area.

- Express appreciation. For example, the son can thank his mom for dinner, rides, etc. Mom can thank her son for keeping a clean room or coming home on time.

- Compliment the other person. For example, one person can compliment the other on his or her appearance, how a chore was done around the house, or how respectful the adolescent was when introduced to a new adult.

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- Give a pleasant surprise. For example, a parent can bring home an ice cream treat. The son or daughter can clean up a room without being asked.

- Express affection. For example, a father could tell his son or daughter, "I love you." A son or daughter could kiss a mother goodbye before going to school.

- Initiate pleasant conversation.

- Offer to help sometime without being asked. For example, a daughter could offer to start dinner or a father could offer to do one of his son's chores when he is working on a school project.

The form has space for additional reminders to be added. While in the session, have the caregiver and adolescent make a list together of other nice things each would appreciate from the other. Work with them to narrow the list down to a few things, and write them on the form.

Review the rules of using the form with the caregiver and adolescent. First, they should remember to engage in one or more behaviors daily (even if the other person does not). Second, the form should be posted in a prominent place where both will have access to it and they can check off when they remember to do something nice. The placement of the list can be discussed during the session. Third, they can add to the list at any time.

For homework, ask the participants to include the entire family in the Daily Reminder To Be Nice activity and to try the procedure for several weeks. Review completion of this homework assignment with the adolescent during the next session, and follow up with the caregiver by telephone.

11. Spend a little time on closure with the caregiver. Remind the caregiver that this will be the last session with him or her, review what was covered in previous sessions and how it went, and thank him or her for participating.

Although you will usually have one or two more sessions with the adolescent, this will be the last formal session with the caregiver. See procedure 12 for the type of information covered in a closure session. Once again, thank the caregiver for participating in treatment. Briefly summarize the progress made. This would also be an appropriate time to tell the caregiver when and under what circumstances he or she might want to contact a substance abuse treatment professional.

12. Complete the *ACRA Procedure 11 Checklist—Caregiver–Adolescent Relationship Skills* immediately after the session.

A blank copy of this form is included at the end of this section.

Relationship Happiness Scale
(Adolescent Version)

Name:_____ **ID:** _____ **Date:** _____

This scale is intended to estimate your current happiness with your relationship with your parent or caregiver in each of the areas listed below. You are to circle one of the numbers (1 to 10) beside each area. Numbers toward the left end of the 10-unit scale indicate various degrees of unhappiness, whereas numbers toward the right end of the scale reflect increasing levels of happiness. Ask yourself this question as you rate each life area: "How happy am I today with my parent in this area?" In other words, indicate according to the numerical scale (1 to 10) exactly how you feel today. Try to exclude feelings of yesterday and concentrate only on the feelings of today in each of the life areas. Also, try not to allow one category influence the results of the other categories.

	Completely Unhappy									**Completely Happy**
1. Time spent with me	1	2	3	4	5	6	7	8	9	10
2. Allowance	1	2	3	4	5	6	7	8	9	10
3. Communication	1	2	3	4	5	6	7	8	9	10
4. Affection	1	2	3	4	5	6	7	8	9	10
5. Support of school/work	1	2	3	4	5	6	7	8	9	10
6. Emotional support	1	2	3	4	5	6	7	8	9	10
7. General happiness	1	2	3	4	5	6	7	8	9	10
8. General home activities	1	2	3	4	5	6	7	8	9	10

Sample

Relationship Happiness Scale
(Adolescent Version)

Name: *John Doe* ID: *1234* Date: *3-1*

This scale is intended to estimate your current happiness with your relationship with your parent or caregiver in each of the areas listed below. You are to circle one of the numbers (1 to 10) beside each area. Numbers toward the left end of the 10-unit scale indicate various degrees of unhappiness, whereas numbers toward the right end of the scale reflect increasing levels of happiness. Ask yourself this question as you rate each life area: "How happy am I today with my parent in this area?" In other words, indicate according to the numerical scale (1 to 10) exactly how you feel today. Try to exclude feelings of yesterday and concentrate only on the feelings of today in each of the life areas. Also, try not to allow one category influence the results of the other categories.

	Completely Unhappy									Completely Happy
1. Time spent with me	1	2	3	4	5	6	7	(8)	9	10
2. Allowance	1	2	3	4	5	6	7	8	(9)	10
3. Communication	1	2	3	(4)	5	6	7	8	9	10
4. Affection	1	2	3	4	5	6	7	8	(9)	10
5. Support of school/work	1	2	3	(4)	5	6	7	8	9	10
6. Emotional support	1	2	3	4	5	6	7	(8)	9	10
7. General happiness	1	2	3	4	5	6	7	(8)	9	10
8. General home activities	1	2	3	4	5	6	7	(8)	9	10

Relationship Happiness Scale
(Caregiver Version)

Name:_____ **ID:** _____ **Date:** _____

This scale is intended to estimate your current happiness with your relationship with your adolescent in each of the eight areas listed below. You are to circle one of the numbers (1 to 10) beside each area. Numbers toward the left end of the 10-unit scale indicate various degrees of unhappiness, whereas numbers toward the right end of the scale reflect increasing levels of happiness. Ask yourself this question as you rate each area: "How happy am I today with my adolescent in this area?" In other words, indicate according to the numerical scale (1 to 10) exactly how you feel today. Try to exclude feelings of yesterday and concentrate only on the feelings of today in each of the life areas. Also, try not to allow one category influence the results of the other categories.

	Completely Unhappy									**Completely Happy**
1. Household responsibilities	1	2	3	4	5	6	7	8	9	10
2. Communication	1	2	3	4	5	6	7	8	9	10
3. Affection	1	2	3	4	5	6	7	8	9	10
4. Job or school	1	2	3	4	5	6	7	8	9	10
5. Emotional support	1	2	3	4	5	6	7	8	9	10
6. General happiness	1	2	3	4	5	6	7	8	9	10
7. Time spent with adolescent	1	2	3	4	5	6	7	8	9	10
8. General home atmosphere	1	2	3	4	5	6	7	8	9	10

Sample

Relationship Happiness Scale
(Caregiver Version)

Name: *John Doe* ID: *1234* Date: *3-1*

This scale is intended to estimate your current happiness with your relationship with your adolescent in each of the eight areas listed below. You are to circle one of the numbers (1 to 10) beside each area. Numbers toward the left end of the 10-unit scale indicate various degrees of unhappiness, whereas numbers toward the right end of the scale reflect increasing levels of happiness. Ask yourself this question as you rate each area: "How happy am I today with my adolescent in this area?" In other words, indicate according to the numerical scale (1 to 10) exactly how you feel today. Try to exclude feelings of yesterday and concentrate only on the feelings of today in each of the life areas. Also, try not to allow one category influence the results of the other categories.

	Completely Unhappy									Completely Happy
1. Household responsibilities	1	2	3	4	5	6	7	(8)	9	10
2. Communication	1	(2)	3	4	5	6	7	8	9	10
3. Affection	1	2	3	4	5	6	7	8	(9)	10
4. Job or school	1	(2)	3	4	5	6	7	8	9	10
5. Emotional support	1	2	3	4	5	6	7	(8)	9	10
6. General happiness	1	2	3	4	5	6	(7)	8	9	10
7. Time spent with adolescent	1	2	3	4	5	6	(7)	8	9	10
8. General home atmosphere	1	2	3	4	5	6	7	(8)	9	10

Date _____ Session # ____ Adolescent ID___ Therapist Init. _____

ACRA

Daily Reminder To Be Nice

Name:_____ Week Starting:_____

	Day						
Activity	**Sun**	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**
Did you express appreciation to the other person today?							
Did you compliment the other person on something?							
Did you give the other person a pleasant surprise?							
Did you express affection?							
Did you initiate pleasant conversation?							
Did you offer to help?							

Date_____ Session #_____ Adolescent ID_____ Therapist Init._____

ACRA Procedure 11 Checklist—
Caregiver–Adolescent Relationship Skills

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you thank both for coming to the session?			
2. Did you provide an overview for the session?			
3. Did you check to see whether there was anything pressing?			
4. Did you have each say three positive things about the other?			
5. Did you review communication skills?			
6. Did you discuss the importance of limiting "No's"?			
7. Did you review problem-solving skills?			
8. Did you do some roleplays for both problem-solving and communication skills?			
9. Did you have both complete *Relationship Happiness Scale* forms?			
10. Did you go over the *Daily Reminder To Be Nice* form?			
11. Did you go over closure with the caregiver?			

Procedure 12: Treatment Closure

Rationale

As the treatment sessions end, the adolescent needs to feel positive about the treatment and the progress he or she has made. Having the therapist acknowledge the hard work during the treatment sessions helps the adolescent reinforce the skills learned and provides motivation to access additional services in the future, if they are needed.

Purpose of the Procedure and Learning Objectives

The purpose and learning objectives of this session are to make certain the adolescent understands and acknowledges the progress he or she has made during treatment and receives praise for the progress and hard work. The adolescent must also understand procedures that will continue to help him or her be substance free.

Timing, Audience, and Delivery Method

The closure session is conducted individually with the adolescent and should be delivered in the last treatment session. If, however, it becomes clear that an adolescent is "dropping out" of treatment early, the therapist should make an effort to get the adolescent back for one more session and implement these closing session procedures.

Materials

General materials include snacks (e.g., chips, crackers, granola bars, fruit bars), drinks (e.g., milk, fruit juice, caffeine-free soda), chairs, and (if applicable) a videocamera and videotapes or an audiorecorder and audiotapes.

Procedure-specific materials include clipboard, pens, a discharge packet, *Relationship Happiness Scale* form, happiness scales completed during sessions 1 through 11, completed *Goals of Counseling* forms, completed *Functional Analysis of Substance Use Behavior* forms, completed *Functional Analysis of Prosocial Behavior* forms, completed functional analysis (relapse version) forms, personalized resource activity list, and certificate of completion.

General Notes for the Therapist

The goal of the discharge session is to review progress made during treatment by briefly reexamining the functional analyses and *Relationship Happiness Scale* and *Goals of Counseling* forms. The therapist should (1) reinforce progress made toward goals, (2) discuss with the adolescent whether he or she would like to set additional goals in areas in which a goal was completed, and (3) discuss progress made toward achieving unmet goals. The therapist should provide positive expectations for success for the adolescent with statements like, "You have done a really good job while in treatment, and I think you will achieve all your goals outside of treatment, too." Ask the teenager how he or she feels about ending treatment, and discuss any concerns.

Procedural Steps

1. Check with the adolescent, and provide an overview of the session.

2. Review the adolescent's progress.

3. Talk with the adolescent about what he or she has gained from the treatment experience.

4. Provide the adolescent with reference information on procedures that have been covered during treatment.

5. Reinforce the adolescent's efforts and hard work.

6. Review the status of other referrals made during treatment and the options for future treatment.

7. Consider other optional activities appropriate for a closing session, such as joint completion of a discharge form and giving the adolescent a completion certificate.

8. Complete the *ACRA Procedure 12 Checklist—Treatment Closure* immediately after the session.

Detailed Description

The remainder of this section contains a step-by-step description for conducting the closing session. Procedural steps are in **bold type**, and they are followed by further directions and comments. Sample dialogs between a therapist and an adolescent are indicated in *italic type*.

1. Check with the adolescent, and provide an overview of the session.

Take a few minutes at the beginning of the session to check how the teenager is doing, and provide a framework for what will be covered during the closing session.

Therapist: *Last time when we met, you were going to try using the Daily Reminder To Be Nice technique. How has that been going?* (See procedure 11 for description of these procedures.)

Adolescent: *It's going pretty well. I've been telling my mom that I love her, and she has been making more pasta for me.*

Therapist: *That sounds good. What I would like to do today is for us both to talk about the progress you've made in treatment. We will talk about what it means to be "discharged" and some of the things that could happen now. I'm going to give you some information that can help you remember some of the things we did.*

2. Review the adolescent's progress.

A good way to review a teenager's progress is to look at previous *Goals of Counseling* forms and talk about what goals have been accomplished. Another helpful review is to compare *Relationship Happiness Scale* forms that were completed over the course of treatment. Often these will reflect a pattern of improvement. It would also be important to discuss any unmet goals from prior *Goals of Counseling* forms and help clarify plans for achieving these goals.

Therapist: *First of all, let's discuss your first goal, which was to get at least a "C" in all of your classes. How is this going?*

Adolescent: *I've been doing pretty well. I'm not doing as well as I want to do yet.*

Therapist: *How about algebra?*

Adolescent: *I had a makeup test. But I don't know what my grade is in there.*

Therapist: *You probably want to check on that. Remember that you can also use those problem-solving procedures to think of other ways to get help for your difficult subjects. That can help you out. You've done really well with that—figuring out different solutions. That is something I really appreciate about you.*

Another goal was to stay clean for 50 days to a year. Making it to 50 days was a first milestone. You have almost made it this long, and you've done really well. You had one time that you had a problem, and you said that you were going to bring in your cousin for the early warning system. Have you talked to her about that?

Adolescent: *I've talked to her about that, and she is supposed to remind me about my goal if she notices me hanging out with Mike and Mark.*

Therapist: *One of the other things you did was look at different activities you could have fun at, while staying away from drugs and alcohol when you were doing them. What are some of the things you really enjoyed?*

Adolescent: *I went and played pool at the university's bowling and billiard center, and I thought that was pretty cool.*

Therapist: *What are some other things that you've done?*

Adolescent: *I went bowling with a couple of friends. I spent the night at a friend's house after her grandfather's retirement party.*

Therapist: *And you also mentioned that you wanted to play laser tag. So this is something. The good thing is that you were having fun and you got to do something and got your mind off things.*

Let's review your functional analysis of substance use a little. You know, when we talked about your outside and inside triggers, one of the things that is a little different is that you said, if you were bored, you would get restless and smoke pot. We talked about how a positive thing you got out of using marijuana was that it kept you from getting bored. But we also talked about the bad things that happened when you used, including that your mom and sister would get upset about it and you were spending your money, which was bad because you needed your money, and you had some legal problems. Now when you smoked with Mike, it was really different—you were kind of anxious. That was kind of a different situation. What could you have said to yourself?

Adolescent: *Well, I could have thought about some of the bad things that happen when I use.*

Therapist: *Good. And this was one of the things you did a really good job of when you were meeting with me . . . talking about ways to keep things from happening. And most of the time you were successful doing this when you were out there in your "real life." One of the other things is to find another activity you enjoy doing instead. We went through a prosocial functional analysis about taking care of your iguana, and that activity was good because, when you did it, you didn't have to*

worry about getting in trouble as you did when smoking marijuana.

3. Talk with the adolescent about what he or she has gained from the treatment experience.

When the adolescent verbalizes treatment benefits, it helps reinforce new behaviors he or she has learned.

Therapist: *We've worked on a lot of things, and you've done really well with things including problem solving and relapse prevention. What are some things you think you gained from being in treatment?*

Adolescent: *I actually want to go out and do stuff instead of going out and getting high.*

Therapist: *And what is something that you like about that?*

Adolescent: *It gets me out of the house and people don't think I'm ignoring them.*

Therapist: *So it has improved your relationship with your friends. That's not something we really have talked about. Has it improved your relationship with your friend, Susan? And how about your friends who were attending AA meetings?*

Adolescent: *Yeah, she used to smoke pot and I would do it with her and we just sat at our house. And even when she started going out with Jon—he would call to do stuff and we would just sit around at our house and do nothing. And then I got arrested and I quit smoking pot and stuff and quit hanging out with Susan, and the next thing I know she started coming around again and she was quitting too.*

Therapist: *So she's been supportive of what you wanted and that's helped out too—even though she was not the first person you thought of. Now all these people are really good supports for you. Sounds as if you got some really positive things coming here . . . problem solving and figuring out some other things you could do besides use marijuana.*

Is there anything else you gained from coming here?

Adolescent: *Knowing how to prevent myself from going out and doing drugs. Like before I never thought, oh this would happen if I smoked pot. Now there is a whole thought process that goes through my head about what will happen.*

Therapist: *It sounds as if you are looking at the big picture. There were some things that you liked about smoking pot and before you tended to concentrate on those, but now you are seeing the whole picture. This doesn't surprise me, because you did really well in our sessions talking about these things.*

One thing I'd like to do now is have you fill out a Happiness Scale *form. Let's finish that up and look at some of the changes in your life.*

[Therapist shows the client earlier happiness scales and points out the differences between earlier ones and the current one.]

Therapist: *Here is a difference on relationship with caregivers—from a 6 to a 9.*

Adolescent: *Now it is just easier to talk with my mom. Like yesterday, she started going off on me, and instead of blowing up I just said, "Do you want me to tell you what I did with my money?" And then we just talked about things calmly.*

Therapist: *That's really great. I bet you are both happier when you can do that. I see another difference with education—from a 6 to a 9.*

Adolescent: *Yeah, I was failing my classes. Now my grades have improved.*

Therapist: *It is good because you set some goals and you have worked at them. Communication went from an 8 to 10. Can you tell me what happened there?*

Adolescent: *Well, communication with my friends hasn't changed. But now with my mom and dad, it is better. She listens now, and it is easier to talk with her. She listens to what I have to say. Before she'd just say "You're wrong."*

Therapist: *Sounds really good. Things are working well for you. I'm wondering whether you have any goals from here on out?*

Adolescent: *I'd like to graduate with my class. I'm thinking of taking a correspondence course to help do this. I could do that.*

4. **Provide the adolescent with reference information on procedures that have been covered during treatment.**

Consider providing a discharge packet to each teenager for reference. The contents of the packet can vary based on the individual teenager's needs. Sample material can be found at the end of this section. It is titled *The Road Ahead*. The discharge packet can include the following:

- Information on positive social activities (e.g., activity lists from procedure 2)
- A list of tasks that are a part of each procedure (i.e., goal setting, decision making, communication skills, problem solving, relapse prevention [including use refusal])
- Completed forms including the *Functional Analysis of Substance Use Behavior*, *Functional Analysis of Prosocial Behavior*, and *Goals of Counseling*.

Therapist: *I want to spend a few minutes showing you what is in this packet. These are things we have worked on together, and you can pull them out periodically to help you when you might need them. You don't always have to do them in written form. For example, you can do something similar to the happiness scale in your head. You can ask yourself what things are going well and what things aren't going well in your life and think about what goals you want to set to improve those things that aren't going well.*

The therapist can individualize the forms and packet by using the client's information and input.

5. Reinforce the adolescent's efforts and hard work.

This verbal reinforcement is woven throughout the session as is illustrated in the sample dialog above.

6. Review the status of other referrals made during treatment and the options for future treatment.

If the participant demonstrated needs for additional services during treatment (e.g., residential treatment, psychiatric treatment, family counseling), appropriate referrals should have been made when these needs became apparent. (See discussion in Part II, Overview of the Treatment Model.) However, this is the time to review the teenager's progress with these other services and reinforce continued involvement with them, if needed. Talk with the adolescent about how to access additional services in the future, if needed. The discharge packet can include contact information for resources if the client needs additional services (e.g., mental health treatment) in the future. Include contact information for substance abuse problems the client may experience in the future.

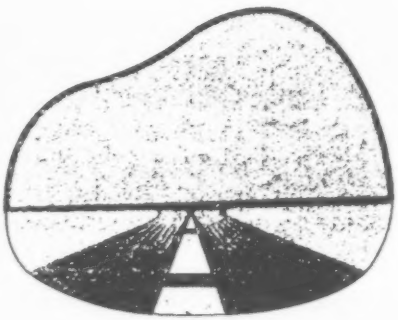
Other options are an open invitation for the teenager to call the therapist if he or she feels the need to in the future or scheduling a monthly call from the therapist for a limited time. Consider scheduling a followup appointment within 2 to 3 months as well.

7. Consider other optional activities appropriate for a closing session, such as joint completion of a discharge form and giving the adolescent a completion certificate.

Optional activities during this session depend on the treatment provider. For example, if the treatment provider has a standard discharge form that needs to be completed for the clinical record, then you and the adolescent can fill it out together so that the teenager is fully aware of what his or her discharge recommendations are. Some therapists give adolescents a completion certificate or some other symbol to indicate that they have completed the program.

8. Complete the *ACRA Procedure 12 Checklist—Treatment Closure* immediately after the session.

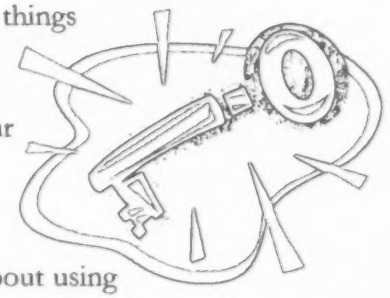
A blank copy of the form is included at the end of this section.



THE ROAD AHEAD

(Sample Discharge Packet)

WHAT LEADS TO USE?



When evaluating alcohol or drug use, we looked at things that happened before you used alcohol or drugs and the positive and negative consequences of the use. The things leading up to use could include your being around certain people, your being at a particular place, a certain time of day, or some thoughts or feelings that come to mind. We called those things triggers, things that make you think about using alcohol or drugs. Remembering what situations you used alcohol or drugs in can be important in realizing some high-risk situations for use. Triggers make the use of alcohol or drugs more likely, which in turn leads to both positive and negative consequences.

Triggers → Behavior → Consequences

Example	Hanging out with Joe before school at his house →	smoking marijuana →	(-) getting grounded, not wanting to do homework (+) not thinking of school.

Is there a way to get some of the things you like, the positive consequences, without getting some of the things you don't like? Finding activities that you like can help. An activity like shooting baskets may be something fun you could do with a friend and could give you time to forget about stress in school without having to worry about it affecting your grades or your getting grounded or arrested. You end up getting the things you want without the negative consequences. You can always review lists of possible activities to see whether there are some new things you would like to try (see following page). Of course, just as in the example above, triggers for a positive activity make the activity more likely and lead to positive and negative consequences. The difference is that these activities tend to have more long-term positive consequences and fewer short-term negative consequences than alcohol or drug use.

Activities That May Interest You

Aircraft Flight Instruction:

Metro-East Airport (Shafer Field)	2070 Triad Rd., St. Jacob	644–5411
Langa Air, Inc.	10 Terminal Dr., East Alton	(314) 895–8911

Amusement Places:

Aladdin's Castle	133 St. Clair Sq., Fairview Hts.	632–1027
Family Fun Tyme	8 Gateway Dr., Collinsville	344–7747
Family Fun Tyme	1 Schiber Ct., Maryville	288–7747
G & B Amusement Co.	6930 W. Main, Belleville	397–7609
Games People Play	699 S. Bluff Rd., Collinsville	345–0885
Time Out	131 St. Clair Sq., Fairview Heights	632–1027
Time Passages Arcade	321 Broadway, Alton	465–1270

SAMPLE

Amusement Parks:

Six Flags	I-44 & Allenton Rd., Eureka	(314) 938–4800

Antiques:

Alton Landing Antiques	110 Alton St., Alton	462–0443
Antique Emporium	100 E. Warren, Bunker Hill	585–3929
Broadway Antiques	217 E. Broadway, Alton	465–0423
Belleville Antique Mall	208 E. Main, Belleville	234–6255
Richard's Antiques	2 N. Main, Wood River	254–5793
Maryville Antique Mall	2114 S. Center, Maryville	345–5533
MC Antiques and More	126 E. Chain of Rocks, Granite City	797–2581
Pywacket Antiques	215 E. Central, Benld	(217) 835–2970
Wagon Wheel Antiques	National & Academy, Pocahontas	669–2918

Aquariums (Public):

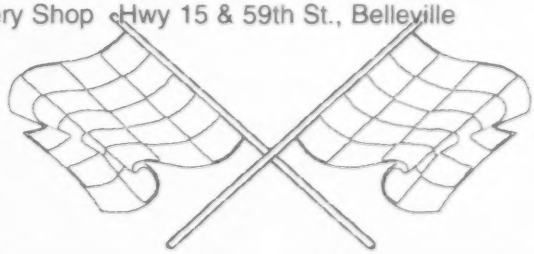
Mid-America Aquacenter	416 Hanley Industrial Ct.	(314) 647–9594

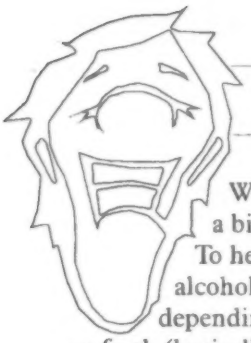
Aquariums:

Aqua Pets	5733 Godfrey Rd., Godfrey	466–3474
Oceans Windows Pets	2755 E. Broadway, Alton	462–6353
The Swamp	2324 Nameoki Rd., Granite City	451–1852

Archery Ranges:

Bullseye Archery	405 E. U.S. Hwy 40, Troy	667–8616
Town Hall Archery Shop	Hwy 15 & 59th St., Belleville	235–9881





RESISTING PRESSURE TO USE

When you decide to abstain from alcohol or drug use, it can be a big change. People will probably still offer you alcohol or drugs. To help you reach your goal, it is important to know how to refuse alcohol or drugs. Refusing drugs may be easy or more difficult depending on whom you are with, where you are, the time of day, and so forth (basically any of the triggers). Being prepared by practicing use refusal skills can help you stay away from drugs and reach your goal. Below are the basic steps to use for refusing alcohol or drugs.

- **Say, "No, Thanks"**
- **Use Good Body Positioning**
- **Suggest an Alternative**
- **Change the Subject**
- **Confront the Aggressor**

- **Say, "No, Thanks."** Of course, if someone offers you alcohol or drugs, saying "no, thanks" is the first thing you would want to do. To make sure he or she knows you are serious, be firm. Often strangers or acquaintances will just accept a "no thanks" without pressuring you any more. However, other people such as friends may want to have an explanation. Having a readymade explanation ("No, thanks, I'm not feeling too well tonight") can make it easier. You may decide to just tell them directly that you do not want to use drugs any more and why.

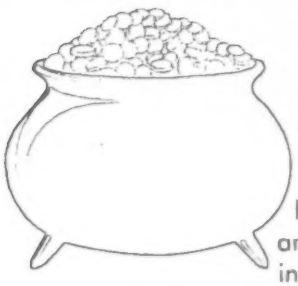
- **Use Good Body Positioning.** Be aware of your posture and body positioning. To get your point across and show you are serious, it is best to look directly at the individual when refusing alcohol or drugs.

- **Suggest an Alternative.** For example, if someone offers you a beer, you might say something like, "No, thanks. How about a soda?"

- **Change the Subject.** This shows that you are not really interested in using drugs. For example, say, "No, thanks. What did you think of that new CD?"

- **Confront the Aggressor.** Use this technique as a last resort. It can strain a relationship at times. If the individual is persistent you may ask, "Why is it so important to you that I do this?"

GOALS



Goals are about what you want in your life. We spent some time completing the *Relationship Happiness Scales* and set goals while we were working together. The happiness scales helped identify what areas of life were going well and what areas needed a little more work. If something was going well in a particular area (such as school or family relationships), it is important to remember what you were doing to help make that area of your life satisfying. If you felt bad about a particular area, you could ask yourself, "What could make this area of my life better?" In the areas that you rated lower on the happiness scales, we developed some goals. Below are some tips to remember in the area of goals and goal setting.

1. **Evaluate areas of your life.**

- What are some areas of your life that are going well? For example, if you are doing well in school, examine what is making school satisfying for you.

- What are some areas of your life that you would like to improve? For example, if you are unhappy with your relationship with your parents or caregivers, examine what you would like to see different or changed.

2. **Define your goal.**

- Keep goals brief, positive, and specific. A specific goal will allow you to see whether you have reached your goal. Be specific about exactly what you would like to see different or changed.

- Make sure your goal is not too complex. It may take several steps to reach a long-term goal. For example, it may require going to school, getting good grades, and getting a good score on the ACT or SAT to get into college. Each one of those small steps needs to be tackled first before you can reach the long-term goal.

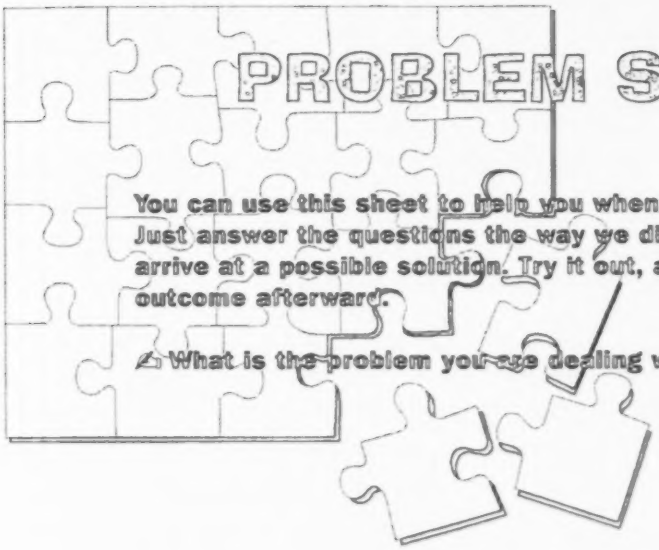
3. **Determine how can you reach that goal.**

Use problem solving (see problem-solving sheet on the next page) to identify ways to reach your goal. Decide on how often you will try a plan of action needed to reach your goal.

4. **Evaluate progress toward your goal.**

Periodically, see what progress you are making toward your goal. Check any changes you think you may need to make or any new things to try to reach your goal. If desired, record progress toward your goal so you can see how far you've come.

PROBLEM SOLVING



You can use this sheet to help you when you have problems to solve. Just answer the questions the way we did during our sessions to arrive at a possible solution. Try it out, and then evaluate the outcome afterward.

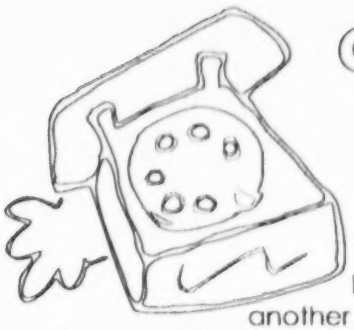
✍ **What is the problem you are dealing with?**

✍ **What are some ways you might be able to solve the problem? List as many ideas as you can think of.**

✍ **Draw a line through any ideas that you don't think you would try.**

✍ **Read each idea that you have not crossed off the list, and pick one idea that sounds like something you would like to try. Write it down below.**

✍ **Evaluate the outcome. Were you satisfied with how it worked out? (You can modify or change the solution or even come up with an entirely new solution if the old solution did not work as planned.)**



COMMUNICATION SKILLS

The goal of using communication skills is to be able to get your message across to another person to help you get what you want. Through use of communication skills, individuals should be able to come to a compromise or agree on a solution to a problem. When everyone agrees on a solution, compliance by all sides and contentment with the solution are more likely. It is important to stay positive while using communication skills and avoid any blaming.

1. **Understanding statement:** The goal of the understanding statement is to open up communication and show that you are aware of the other person's thoughts on the problem.

    - Come from their perspective.
      Example: "Mom, I understand you would like my room clean because it is a real mess and you would like the house to be clean when friends come over."

    - Come from your perspective.
      Example: "But Jimmy is having a party at his house and I have not seen Jimmy in a while, so I would really like to go."

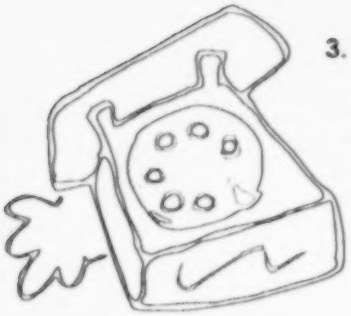
    - Make a request (a request should be brief, positive, and specific).
      Example: "I would really appreciate if you would let me clean my room later on tonight, maybe around 8 p.m. when I get home."

2. **Partial responsibility:** The goal of the statement of partial responsibility is to avoid blaming the other person. Remember to state how you or the other person sees you fitting into the problem or solution.

    - How do you fit in to the problem?
      Example: "I know I made a real mess by not putting my clothes away, and I have not always cleaned my room, and I am sorry about that."

    - Repeat the request (optional).
      Example: "But I would really appreciate if you would let me clean my room around 8 tonight after I get home from Jimmy's party."

(Continued on next page)



3. **Offer to help:** The offer to help is used to show that you are willing to work on a solution that works for everyone and that you would like input on possible solutions.

    - Offer several possible solutions. Example: "If there is anything I can do to help make that happen: help out with another chore around the house, help out with dinner, or just do a quick 10-minute cleaning for now and do the rest later, I would really appreciate it."

- State your openness to listen and consider the other person's ideas. Example: "If there is anything that you can think of, I would be willing to listen."

Following the offer to help, individuals may try to compromise with each other on a solution or do some problem solving. It may be necessary to go through the communication skills again to state your point.

Date_____ Session #_____ Adolescent ID_____ Therapist Init._____

ACRA Procedure 12 Checklist—
Treatment Closure

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you check with the adolescent and provide an overview of the session?			
2. Did you review the adolescent's progress?			
3. Did you discuss any unmet goals on the *Goals of Counseling* form and plans for achieving them?			
4. Did you talk with the adolescent about what he or she has gained from the treatment experience?			
5. Did you provide and review the discharge packet?			
6. Did you reinforce the adolescent's efforts and hard work?			
7. Did you discuss with the adolescent options for further contact and/or treatment?			

Optional Procedure 1: Dealing With Failure To Attend

Many of the tasks in this procedure are based on the *Motivational Enhancement Therapy Manual* used in Project MATCH (Miller et al., 1995). As described in detail below, the therapist's job is to be aggressive in his or her efforts to engage both the adolescent and the caregiver in the ACRA treatment process. This approach includes contacting someone as soon as possible after a missed session and eliciting from him or her the motivations for attending treatment and ceasing substance use.

Rationale

For the adolescent to benefit from treatment, he or she has to attend. If the adolescent quits coming to his or her treatment appointments, it is critical that you reach out to the adolescent and reengage him or her in treatment. It is also important for caregivers to attend the sessions designed for them and, if they do not, the therapist needs to make additional efforts to engage them. Consider this outreach activity as part of your job description.

Purpose of the Procedure and Learning Objectives

The purpose of this procedure is to reschedule the missed appointment and to encourage the adolescent or caregiver to reengage or engage in the treatment sessions. The learning objectives are to provide an opportunity to clarify the reasons for the missed appointment, show the adolescent or caregiver that you are optimistic about the prospects for change, and express your eagerness to see the individual again.

Timing, Audience, and Delivery Method

The timing for this procedure is as soon as possible after a teenager or caregiver misses a scheduled appointment. The target audience is the adolescent and his or her caregivers. These procedures may begin with a telephone contact, but they may also include a home visit, if necessary. If the adolescent has been required to attend treatment by a probation officer, school official, or another authority figure, contact with this official to prompt the adolescent to attend may be warranted.

Materials

None.

Procedural Steps

1. Try to reach the adolescent or caregiver by phone immediately, and keep trying until you reach him or her.

2. If the adolescent or caregiver does not have a phone, make a home visit and conduct the procedures there.

3. If the adolescent does not respond to the procedures, consider contacting a caregiver and the referral source to see whether they can help prompt attendance.

4. Complete the *ACRA Optional Procedure 1 Checklist—Dealing With Failure To Attend* immediately after contacting the adolescent or caregiver.

Detailed Description

The remainder of this section contains a more detailed overview for dealing with failure to attend sessions. Procedural steps are in **bold type**, and they are followed by further directions and comments. A sample dialog between a therapist and an adolescent is indicated in *italic type*.

1. Try to reach the adolescent or caregiver by phone immediately, and keep trying until you reach him or her.

Respond immediately when an adolescent or caregiver misses a scheduled appointment. Try to reach him or her by telephone, and when you do, cover these points:

- Clarify the reasons for the missed appointment.
- Affirm the adolescent or caregiver. Provide reinforcement to him or her for having agreed to participate in treatment.
- Express your eagerness to see the individual again.
- Remind the individual about the reinforcers already discussed for quitting substance use or, in the case of the caregiver, the reasons the caregiver wants his or her child to quit using substances.
- Express your optimism about the prospects for change.
- Reschedule the appointment.

Here is an example of a telephone call from a therapist to an adolescent who has missed treatment:

Therapist: *Hello John! How are you doing?*

Adolescent: *Fine.*

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Therapist: *Good. I was just calling because you missed your appointment today. Was there anything wrong that led to your missing the appointment?*

Adolescent: *Well, my mom wasn't home, and I didn't have a ride, so I couldn't come.*

Therapist: *Okay. I know you really wanted to work on your relationship with your mom, and I think we can work on making things work out between you two in therapy. I really look forward to starting back on this problem during one of our sessions. Is there anything I can do to help you out with getting to therapy?*

Adolescent: *No, not really. My mom just needs to take me.*

Therapist: *Okay. If you need anything, just ask. How are you feeling about therapy now?*

Adolescent: *I really don't feel like coming all the time.*

Therapist: *Well, I realize it isn't always easy to come to therapy and try something like this. I think I might have a hard time coming to therapy at first. What is something you don't really like about coming to therapy?*

Adolescent: *Nothing really. It just takes up a lot of my time.*

Therapist: *It does take up time. One good thing is that it only lasts a few more weeks and then we will be done. I know you had a few reasons why you came here in the first place and some problems because of alcohol and drugs. What are those things?*

Adolescent: *I went because my probation officer sent me. I got in trouble with him, and my mom doesn't really like me smoking weed either.*

Therapist: *What would you like to see happen differently between you and your mom or probation officer?*

Adolescent: *I just want them to stop bothering me.*

Therapist: *I think we can work on that. I would really like to see your mom and probation officer off your back, too. Do you think we could go ahead and reschedule your appointment?*

Adolescent: *Okay. How about Monday night?*

Therapist: *Sounds good. Is 6 still good?*

Adolescent: *Yeah.*

Therapist: *Great. I really look forward to seeing you and working on what to do to get your mom and probation officer to stop bothering you.*

If no reasonable explanation is offered for the missed appointment (e.g., illness, transportation breakdown), explore with the teenager or caregiver whether the missed appointment reflects any of the following:

- Uncertainty about whether treatment is needed (e.g., "I got everything I needed from residential treatment" or "My child doesn't really have a problem")
- Ambivalence about making change
- Frustration or anger about having to participate in treatment (e.g., because the school requires it).

The therapist should not act surprised about the poor attendance or confront the individual with poor motivation or intent. Instead, suggest that it is normal to express reluctance by not showing up or being late, and encourage him or her to express any concerns about participation. Elicit motivational statements from the adolescent or caregiver by having him or her review the negative consequences (with peers, family, school, law enforcement, etc.) that brought the adolescent to treatment in the first place. Then ask the individual to review how the therapist can assist in preventing these things from happening again. If speaking with a caregiver, talk about the goals the caregiver has for his or her adolescent or the problems the adolescent's use creates.

2. If the adolescent or caregiver does not have a phone, make a home visit and conduct the procedures there.

If you suspect flagging motivation, you may need to offer home visits to prime attendance. A home visit is an option, particularly if the therapist has difficulty making contact by telephone or if the family does not have a telephone. The purpose of this visit is to show the adolescent and caregivers that the therapist is genuinely interested and to encourage attendance at a session. The therapist can go through the procedures outlined above and work through any problems with transportation or other obstacles. Some teenagers prefer to have sessions at their school, and this is another option to explore.

Another useful technique is to send out greeting cards to motivate attendance and encourage reengagement in treatment. A handwritten message from the therapist provides a very personal contact for the teenager.

3. **If the adolescent does not respond to the procedures, consider contacting a caregiver and the referral source to see whether they can help prompt attendance.**

If the caregiver does not attend sessions, consider contacting the referral source for help or consider inviting an alternative caregiver.

4. **Complete the *ACRA Optional Procedure 1 Checklist—Dealing With Failure To Attend* immediately after contacting the adolescent or caregiver.**

A blank copy of this form is included at the end of this section.

Date_____ Session #____ Adolescent ID____ Therapist Init._____

ACRA Optional Procedure 1 Checklist—
Dealing With Failure To Attend

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you respond immediately?			
2. Did you clarify the reasons for the missed appointment?			
3. Did you express your eagerness to see the adolescent or caregiver?			
4. Did you talk about the reinforcers that the adolescent had identified to stay away from drug use or in the case of the caregiver why it is desirable for his or her child to become substance free?			
5. Did you express your optimism about the prospects for change?			
6. Did you reschedule the appointment?			
7. Have you sent a greeting card?			
8. If you were unable to make contact by phone, did you try a home visit?			

Optional Procedure 2: Job-Seeking Skills

Rationale

Because a major tenet of ACRA is to encourage positive activities, an activity to consider for many teenagers is employment. The job-finding procedure has been an important part of the community reinforcement approach since its inception. The activities described here have been successful in helping people find jobs.

Working is not necessarily appropriate for all adolescents because balancing school work and other positive prosocial activities during the school year may be all that some adolescents can handle. If, however, they have a lot of free time during the school year, they are not attending school in the summer, or they have dropped out, adolescents may find working to be a reasonable prosocial activity. Some work situations have a culture of alcohol or drug abuse, and one must evaluate this aspect of a potential work environment. Unfortunately, these cultural aspects of the work setting may not become evident until after the adolescent starts the job.

Purpose of the Procedure and Learning Objectives

The main purpose for this procedure is to teach the adolescent how to be proactive in his or her job search. The learning objectives are to provide the adolescent with a realistic, systematic approach to finding a job: decide which job categories are of interest, develop a list of contacts for job leads, inquire about job openings and ask for an application, and track job-finding efforts.

Timing, Audience, and Delivery Method

Job-finding-skills training takes place individually with the adolescent. Schedule the training for a particular session or introduce the topic when the adolescent talks about his or her desire to find a job.

Materials

General materials include snacks (e.g., chips, crackers, granola bars, fruit bars), drinks (e.g., milk, fruit juice, caffeine-free soda), chairs, and (if applicable), a videocamera and videotapes or an audiorecorder and audiotapes.

Procedure-specific materials include clipboard, chalkboard or whiteboard, pens, markers or chalk, possibly an easel, and possibly a *Finding a Job* handout.

A phone, phone directory, and transportation for job interviews are also needed. Most teenagers are qualified only for unskilled jobs, and many may be looking for their first job. If the teenager has work experience or special skills, you may want to provide assistance with resume development, so access to a computer and printer would be helpful.

General Notes for the Therapist

It will not be possible to review all the topics described here in one session. For example, discussion of how to keep a job will be best addressed after the teenager has a job. The initial emphasis will be on locating a job.

Procedural Steps

1. Provide the adolescent with an **overview** of the job-finding approach.

2. Help the adolescent decide which **job categories** he or she is most interested in.

3. Develop a list of **contacts** for job leads.

4. **Roleplay** how to inquire about job openings and ask for an application.

5. **Roleplay** a job interview.

6. Teach the adolescent how to **track** his or her job-finding efforts.

7. **Monitor** the adolescent's performance on the job.

8. Complete the *ACRA Optional Procedure 2 Checklist—Job-Seeking Skills* immediately after the session.

Detailed Description

The remainder of this section contains a more detailed overview for conducting job-finding activities with an adolescent participant. Procedural steps are in **bold type** and are followed by further directions and comments. Provide a copy of the handout *Finding a Job* located at the end of this procedure.

1. Provide the adolescent with an overview of the job-finding approach.

Important points to state are:

- It may take a lot of effort to get a job. If you really want one, then you need to make a job out of looking for a job.
- Being rejected is part of the job-finding process. Do not be discouraged if this happens.
- A first step is to generate a list of job areas that interest you.
- Research shows that the more interviews you have, the better your chances of finding a job.

- It is important to make a lot of contacts to generate job leads, and there are ways to do this.

- You need to learn how to fill out an application.

- You need to practice approaching employers and interviewing.

2. Help the adolescent decide which job categories he or she is most interested in.

It is important to help the teenager identify job areas that interest him or her. As noted, job possibilities will be limited because of age, educational level, and experience. The following questions can help identify interest areas:

- What kind of work have you done?
- What job training have you had?
- What type of place would you like to work in?
- What would you like to do?

A few possible job categories are restaurant work, retail jobs, maintenance, and car repair. Job leads are more easily generated once possible job categories are identified.

3. Develop a list of contacts for job leads.

Research has shown that the best source of job leads are people one knows, including friends, acquaintances, and family members. Other important sources of leads are past employer or coworkers and the *Yellow Pages*. The more traditional sources, help-wanted ads in the newspaper and job-wanted postings, are still important to use, but they are not to be relied on solely.

Provide information about generating a list of leads from each of these sources. Have the teenager actually make a list of friends and family members to contact about job openings. Help the adolescent look through the *Yellow Pages* to identify businesses in the job category he or she would most like to work in and add contact information to the job lead list. The therapist may want to research job-finding resources available in the community and provide this information to the teenager.

4. Roleplay how to inquire about job openings and ask for an application.

Although the approach may vary somewhat depending on the type of job lead, there are some common aspects to approaching an employer about work. Azrin and Besalel (1980) recommend the following approach:

- Tell the person you are looking for a job and why.

- State why you are asking that person for help (e.g., he or she has a job or knows where a lot of other teenagers work).

- Describe your skills briefly.

- Tell the person the kind of help you want (e.g., ask for information on any places he or she has heard are hiring or any position opening signs).

Here are some steps to take when talking with an employer about a possible job:

1. Introduce yourself.
   Hello, my name is _____.

2. Ask for the manager or person in charge (head of department).
   I would like to speak to the manager. Can you tell me his or her name, please?

3. If the person is not available, ask to set up an appointment for the same day or the day after.
   Is there a time today that would be convenient for us to meet?

4. Once you are able to speak with the manager, get to your main point.
   I'm looking for a job in fast food. I'm wondering whether I could come in and talk about a possible job or I'd like to speak with you about possible job openings.

5. Give a brief summary of experience or show enthusiasm for working there.
   This will be my first job. I really would like to work here and you will find me a dependable worker.

5. Roleplay a job interview.

Some adolescents have never had a job interview. You can help them develop their skills in this area by roleplaying interviews with them. For example, you can take the role of the employer, ask typical job interview questions, and coach them in their answers.

6. Teach the adolescent how to track his or her job-finding efforts.

It is important to track the job contacts made each day and their results for several reasons. First, the job seeker may be given specific instructions to call or come back on a certain day. Second, the job seeker may want to identify employers to check back with because they did not have a current opening but anticipated one in the future. Recommend that the teenager keep information in a spiral-bound notebook by date and include the following: name of business, phone number or address, name of person contacted, results of the conversation, and any additional comments. This tracking information provides great reference information for a future job search.

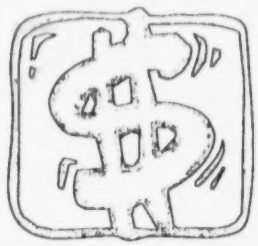
7. Monitor the adolescent's performance on the job.

Once a job is obtained, teenagers may need some additional coaching on how to keep a job. During treatment sessions, the therapist can ask how the job is going and weave in appropriate procedures (e.g., communication and problem solving) to help the adolescent address any problems on the job.

8. Complete the *ACRA Optional Procedure 2 Checklist—Job-Seeking Skills* immediately after the session.

A blank copy of this form is included at the end of this section.

Finding a Job



✔ **Make a list of what you're interested in—what you'd like to do.**

☐ Think of what kind of work you've done in the past. ANY experience you've had matters!

☐ Think about what you're good at or places you'd LIKE to work. Examples: computers, retail (mall), maintenance, waiter (restaurant work), typing, filing.

✔ **Develop a list of contacts for job leads.**

☐ Talk to:
Family members
Friends
Past bosses.

☐ Look in the *Yellow Pages* to locate businesses in the job categories you want to work in.

☐ Look for help-wanted ads posted in windows of stores or restaurants.

☐ Examine help-wanted ads in the newspaper every day.

✔ **Inquire about job openings, and ask for an application.**

☐ Introduce yourself.

☐ Ask for the manager.

☐ Ask whether you can come in and talk about any openings—ask for an interview.

☐ Set up a time the same day or the day after.

☐ Tell the person what work you have done in the past. If he or she is not currently hiring, ask whether you can turn in an application and come back in a couple of weeks.

☐ Ask whether he or she knows of any other businesses that are hiring.

☐ React in a positive and polite manner.

✔ **Develop a resume that includes:**

☐ Your name

☐ Address

☐ Telephone where you can be reached

☐ Work you've done in past

☐ Skills you have

☐ Names and phone numbers of three people for the employer to call as references.

✔ **Set goals when looking for a job.**

☐ Make at least five contacts a day.

☐ Be motivated.

☐ Make a lot of appointments.

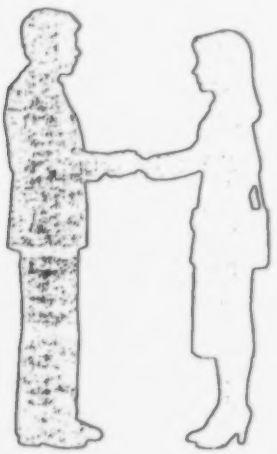
☐ Call employers back to check whether a position has opened up.

☐ Turn in applications to as many places as possible.

(Continued on next page)

Sample request for an interview:

Hello, my name is _____. I would like to talk to the manager. Can you tell me his or her name, please? I'm looking for a job in _____ (e.g., restaurant work), *and I'm wondering whether I could come in to talk about a possible job opening. I can make it at 2 this afternoon; would that be convenient for you? I have experience in _____, and I'd like to talk to you about any openings now or later. Would you have time this afternoon?* (If not) *When is a good time to come back?*



Date_____ Session #_____ Adolescent ID_____ Therapist Init._____

ACRA Optional Procedure 2 Checklist—
Job-Seeking Skills

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you provide an overview of the job-finding approach?			
2. Did you help the adolescent identify job areas he or she was interested in?			
3. Did you help the adolescent develop a list of contacts for job leads?			
4. Did you roleplay with the adolescent how to inquire about job openings and ask for an application?			
5. Did you roleplay a job interview?			
6. Did you teach the adolescent how to track his or her job-finding efforts.			
7. Did you evaluate the outcome at the next session?			

Optional Procedure 3: Anger Management

The following material is adapted from McKay, Rogers, and McKay (1989).[1]

Rationale

Anger-management skills are taught when adolescents or adults express anger in ways destructive to themselves or to the people around them. Managing anger does not guarantee that negative life situations or events will be resolved, but it will assist adolescents in living healthier lifestyles and minimizing the risk of adverse consequences of anger-related behavior.

Purpose of the Procedure and Learning Objectives

The purpose is to promote positive methods of communicating anger that help adolescents express their needs in a safe, effective manner. The learning objectives are to help the adolescent or caregiver:

- Identify reinforcers to manage anger
- Recognize anger
- Take time to "cool down"
- Try to understand another person's position (be empathetic).

Timing, Audience, and Delivery Method

This optional procedure is used when it is evident from assessment information or from what is revealed during treatment that the adolescent or the caregiver has a problem with anger. The procedure is presented individually with the adolescent or the caregivers if needed.

Materials

Procedure-specific material include the *Anger Management* handout.

General Notes for the Therapist

These procedures are to help adolescents who express anger in unhealthy, maladaptive ways. Maladaptive ways are "acting out" frequently in a physically or verbally aggressive manner, passive behavior that is followed by exploding into rage, altercations at school, or screaming matches with parents or caregivers.

One reason that teenagers may be angry is that they have been abused, abandoned, or exposed to other life circumstances for which anger is clearly an appropriate response. In these cases, anger may have helped protect

[1] M. McKay, P.D. Rogers, and J. McKay (1989). *When Anger Hurts: Quieting the Storm Within*. Oakland, CA: New Harbinger Publications. www.newharbinger.com. 800–748–6273.

them from mental or physical harm or alerted them that something in their environments did not feel "right." You can stress to youth, with and without these backgrounds, that it is okay to feel angry; what counts is how they express their anger and negative emotions.

Procedural Steps

1. Identify reinforcers to manage anger.
2. Assist the adolescent in recognizing anger.
3. Teach the adolescent to take time to "cool down."
4. Teach the adolescent to foster empathy.
5. Distribute the *Anger Management* handout.
6. Assign homework.
7. Complete the *ACRA Optional Procedure 3 Checklist—Anger Management* immediately after the session.

Detailed Description

The remainder of this section contains a more detailed overview on how to conduct the optional session on anger management. Procedural steps are in **bold type** and are followed by further directions and comments. A sample dialog between a therapist and an adolescent is indicated in *italic type*.

1. Identify reinforcers to manage anger.

Initially, the therapist focuses on prompting the teenager to identify which anger-related behaviors are interfering with his or her life. Examples might include physical or verbal fighting that has caused trouble for him or her with parents or caregivers and friends. Other consequences of expressing anger in unhealthy ways might include criminal justice involvement or being suspended from school.

Ask the adolescent to tell you how his or her anger has negatively affected goal achievement. Provide an example such as a young man's anger leading to a blowup with his parents, being grounded, and not being able to attend a rock concert. Similar to conducting a functional analysis, the adolescent examines the positive and negative consequences of his or her behavior and is taught to think that there are other, less damaging ways to express anger. Once again, the idea is for you to elicit reinforcers from the adolescent and use these as motivation for change. The following dialog provides an example.

[1] M. McKay, P.D. Rogers, and J. McKay (1989). *When Anger Hurts: Quieting the Storm Within*. Oakland, CA: New Harbinger Publications. www.newharbinger.com. 800–748–6273.

Therapist: *Tell me how your anger has affected you in your life.*

Adolescent: *Well, I got into an argument with my friend Jeff one night, and we ended up getting into a fight. After that we just didn't spend too much time together.*

Therapist: *Has anything else happened that you have not liked because of your anger?*

Adolescent: *I got suspended from school for 5 days once after I was in a fight with a kid. My grades ended up being pretty bad because some of the teachers wouldn't let me catch up on the homework. That's pretty much it, though.*

Therapist: *So you got suspended from school, your grades got worse, and you don't spend much time with one of your friends because of your anger.*

Adolescent: *Yeah, that's right.*

2. Assist the adolescent in recognizing anger.

The first step in helping teenagers express their anger in healthy ways is to assist them in recognizing when they are beginning to feel out of control. This is the point at which they can choose to behave in a damaging or constructive manner. Some teenagers may have more skill in this area than others do, but when adolescents can articulate their "warning signals," they have a better chance of identifying the need to use anger-management techniques. It is not enough that they know anger-management techniques; they also need to know when to use them.

Ask the teenager to describe the physical signs of mounting anger because physiological changes play a part in the body's response to increased arousal. For example, an upset stomach, clenched jaw, sweating, tightened fist, heavy breathing, and a high pulse rate may serve as red flags for the adolescent to step back and cool down. Each adolescent will identify a unique set of physical and behavioral warning signs. Encourage the adolescent to monitor his or her behavior to learn when he or she needs to intervene to avoid an angry response.

Therapist: *Before you get really angry, do you notice any signs that you are getting upset? Some people clench their fists or slam doors or something. Do you notice anything like that?*

Adolescent: *Well, I notice I feel like my face gets really hot, and I start walking around the house really fast, slamming doors as I go.*

[1] M. McKay, P.D. Rogers, and J. McKay (1989). *When Anger Hurts: Quieting the Storm Within*. Oakland, CA: New Harbinger Publications. www.newharbinger.com. 800–748–6273.

Therapist: *Good. Remembering those things can be helpful so when you feel some of those symptoms that show you are getting upset, you can do something else to calm yourself down. That way you don't have to worry about getting really angry and doing something like getting in a fight and getting suspended from school. What is something positive you have done in the past that has helped calm you down when you have started to get angry?*

Adolescent: *Sometimes walking around helps calm me down. When I get angry, I just want to leave and try not to think about things.*

Therapist: *That's great. So you are able to calm down by walking around. What are some of the things you do when you walk around?*

Adolescent: *I just walk around and think of how much a jerk the person was.*

Therapist: *Okay. Some people like trying to do different things—positive activities like shooting some hoops or going to the arcade—when they get angry to help them calm down and get their minds off things for a little while. What kind of positive thing do you think you would try once you started walking around?*

Adolescent: *Well, I sometimes like just going to the park and relaxing to get my mind off things. If I am really angry, I sometimes like to play video games at home.*

Therapist: *So when you start noticing your face getting hot or start walking around really fast slamming doors, you would be willing to walk around and maybe spend some time relaxing in the park or play video games? That sounds as if it might work for you, and you don't have to worry about getting in trouble at school. Would you be willing to try one of these activities the next time you feel yourself getting upset?*

Adolescent: *Sure. If I start getting angry, I'll just walk away and go to the park to calm down.*

Therapist: *That's right.*

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[1] M. McKay, P.D. Rogers, and J. McKay (1989). *When Anger Hurts: Quieting the Storm Within*. Oakland, CA: New Harbinger Publications. www.newharbinger.com. 800–748–6273.

3. Teach the adolescent to take time to "cool down."

One technique that has proved useful for anger management is taking the time to calm down. If a person is in an interpersonal situation during which he or she feels physical signs of mounting anger, he or she is encouraged to say, "I need to cool down," and to leave for an agreed amount of time (e.g., 1 hour). Walking out for a specified time does not constitute running away or punishing the other person, but it allows the individual time to work through the "heat of the moment" and "clear the head."

During the time away, the teenager is encouraged to engage in a physical activity to reduce tension. He or she can go for a walk, play some basketball, or participate in a pleasurable activity. It is *not* a time to use substances. The *Functional Analysis of Prosocial Behavior* form can serve as an adolescent-generated guide to the kinds of activities that might appeal to youth. After the time has passed, the adolescent returns to the situation to talk with the other person or decides to take more time to reduce the tension. Communication skills training is also important to help teenagers learn how to express their anger more productively (see procedure 6).

When the teenager finds himself or herself growing angry outside a conversational context, such as thinking about what someone else did or said, he or she is once again encouraged to engage in tension-reducing activity. Explain that this "cooling down" period prevents him or her from acting impulsively in damaging ways or returning to substance use. Problem-solving techniques may be useful in attempting to resolve the situations to which an adolescent is reacting. Once again, you will want to revisit reasons an adolescent has given to stay clean and manage his or her anger.

4. Teach the adolescent to foster empathy.

Many times when people are angry with someone, they do not think about why the other person has acted in a certain way. Fostering empathy is one method of helping an adolescent learn how to examine situations from different viewpoints and defuse anger with understanding. This ability does not mean that anger in a given situation becomes unjustified, simply that anger can be communicated more effectively when the person on the receiving end feels understood and becomes more receptive to the youth's position.

Particularly with an older adolescent who has reached a higher level of cognitive maturity, you can help the teenager learn to "walk in someone else's shoes." This skill can be taught through roleplaying. For example, you pick a real life situation and play the role of the adolescent. The adolescent can play the role of the person with whom he or she is angry, attempting to voice concern from another point of view.

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[1] M. McKay, P.D. Rogers, and J. McKay (1989). *When Anger Hurts: Quieting the Storm Within*. Oakland, CA: New Harbinger Publications. www.newharbinger.com. 800–748–6273.

Following the roleplay, process the experience with the teenager. Ask what effect the roleplay had on his or her understanding of the other person's position and how he or she would handle the same situation if it happens again.

5. Distribute the *Anger Management* handout.

Explain that this sheet contains reminders that will help the youth identify anger triggers and ways to deal with anger.

6. Assign homework.

Seek agreement from the teenager that he or she will use the anger-management techniques when experiencing the physical precursors to anger. You should review the adolescent's success at using the anger-management techniques in the next session and thereafter when the teenager reports experiencing anger.

7. Complete the *ACRA Optional Procedure 3 Checklist—Anger Management* immediately after the session.

A blank copy of this form is included at the end of this section.

[1] M. McKay, P.D. Rogers, and J. McKay (1989). *When Anger Hurts: Quieting the Storm Within*. Oakland, CA: New Harbinger Publications. www.newharbinger.com. 800–748–6273.

Tips for Individualizing or Dealing With Difficult Situations

- **Anger management is individualized.** Each adolescent will present with a unique set of situations to which he or she responds with anger, as well as different methods of expressing his or her emotions. Listen to each teenager's needs, and respond with interventions targeted to specific problems. For example, adolescents with chronic aggressive behavior may initially require more empathy training and tension-reduction work than adolescents who bottle their emotions until they explode. Those teenagers may respond better to problem-solving and communication skills training.

- **Adolescents are a danger to themselves or others.** One extreme form of anger-management problems may involve adolescents' threats to hurt themselves or others in a fit of rage. In these cases, attempt to fully assess the extent of these intentions and consult with supervisors about the best course of action.

- **Caregivers are aggressive.** Some teenagers may live with caregivers who are physically or verbally aggressive themselves. If you have concerns that the caregiver's behavior is abusive, consult with your supervisor for the best course of action including whether the behavior needs to be reported to the State child welfare authority. Even if the caregiver's behavior does not rise to the level of reportable abuse, it can create a negative situation. Teenagers will have difficulty learning how to manage their negative emotions in a more constructive manner if they live in an environment where anger is routinely expressed in unhealthy ways. Work with the caregiver and the adolescent separately. The caregiver can be helped to improve his or her communication skills while you are working with the teenager to improve his or her anger-management skills.

[1] M. McKay, P.D. Rogers, and J. McKay (1989). *When Anger Hurts: Quieting the Storm Within*. Oakland, CA: New Harbinger Publications. www.newharbinger.com. 800–748–6273.

ANGER MANAGEMENT

Remember, it's okay to get angry. What is important is how your emotions are expressed. Below are some tips for anger management.

- **How has anger interfered with your life?** What would you like to change?

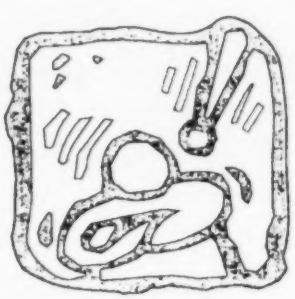
- **How do you know when you are getting angry?** (Typical signs are an upset stomach, clenched jaw, tightened fist.) If you feel you are beginning to get angry, you can do something before the situation becomes too tense and leads to negative consequences.

Write your typical signs here:_____

- **Take time to cool down.** Find an activity or spend time away from the situation so you are able to calm down and handle the situation in a way that does not have negative consequences.

- **Remember to use communication skills to help express how you feel, while trying to see how the other person feels.** Try to come to a common solution instead of forcing your decisions on someone else. See the *Communications Skills* sheet.

- **Try to come from the other person's perspective.** Why does the person feel the way he or she does?



Date_____ Session #_____ Adolescent ID_____ Therapist Init._____

ACRA Optional Procedure 3 Checklist—
Anger Management

Activity	Check Appropriate Boxes		
	In Progress	Yes	No
1. Did you explain the purpose of learning anger-management skills?			
2. Did you probe the adolescent for his or her reason for learning anger-management skills?			
3. Did you ask the adolescent how anger-related behaviors have interfered with goals?			
4. Did you prompt the adolescent for specific physiological and behavioral warning signs?			
5. Did you identify activities in which the adolescent can engage to "cool down" after the warning signals have been recognized?			
6. Did you conduct roleplays with the adolescent to help him or her learn to walk in another person's shoes?			
7. Did you assess the adolescent's potential danger to himself or herself and, if necessary, consult with a supervisor about the issue?			

V. Protocol Monitoring Adherence

Overview of Protocol Monitoring Procedures

A treatment manual is only one of the pieces needed to implement a treatment protocol. A number of additional supports help ensure that the protocol is fully implemented and delivered as outlined in the treatment manual. The following activities are recommended for protocol monitoring: (1) staff training by an experienced ACRA trainer, (2) certification of therapists, (3) individual supervision, (4) group supervision, and (5) quality assurance rating scales and checklists (i.e., *Therapist Skillfulness Scale, ACRA Global Procedure Checklist*, and ACRA individual procedure checklists).

ACRA Training

Training should be provided by an experienced ACRA trainer. Initial training should include a review of the background of CRA and ACRA, an overview of the model, an extensive review of the treatment manual, review of taped examples of treatment sessions delivering the model, and roleplay or practice exercises. Ongoing training can be provided in clinical supervision; however, the trainer providing the initial training should periodically offer refresher or booster training to all staff delivering the model.

Certification of Therapists

A process to certify therapists helps ensure that procedures are being delivered as outlined in the manual. The certification process requires that the therapist videotape and/or audiotape therapy sessions and that all or randomly selected tapes are reviewed and rated by a clinical supervisor. Several forms have been developed to aid in the tape review and the clinical supervision process including (1) the *Therapist Skillfulness Scale* (TSS), (2) the *ACRA Global Procedure Checklist* form, and (3) the ACRA individual procedure checklists. Both consistent ratings of four and five on the TSS and a demonstration by the therapist that he or she is implementing the treatment interventions in a competent and consistent manner are necessary for certification. A more detailed description of the rating scale and the checklists follows.

Therapist Skillfulness Scale

A therapist's working alliance, adherence to the manual, and competence in the treatment being delivered can be assessed by using the TSS. The TSS is used by the ACRA supervisor to rate whether the interventions used in sessions consistently reflected the protocol. The TSS measures competence for a range of skills from nonspecific, basic therapy skills to specific skills related to the manual. This scale is used to provide direction and feedback in supervision. It is important to note that adherence and competence are different constructs. Adherence is how much a therapist uses the procedures, and competence is how well the procedures are implemented with appropriate timing.

One of the items rated on this scale relates to self-disclosure. In the model, self-disclosure would rarely be appropriate. It is included on the scale so that the supervisor can monitor the amount of self-disclosure that occurs and provide appropriate feedback to the therapist. These ratings can be monitored over time to maintain quality of treatment. If ratings decline, it would warrant an increase in training and/or supervision. This scale provides a tool to assess the need for further supervision on specific techniques or interventions. A copy of this scale follows this section.

ACRA Global Procedure Checklist

This form is specific to ACRA procedures and provides an opportunity for supervisors to note what ACRA procedures were used, as well as which ones could have been used. ACRA therapists complete one after each session. The supervisor reviews the completed form and initials it to indicate whether he or she agrees or disagrees with the therapist's designation. The checklist is another tool that can be used to monitor the treatment process. Comparing this information with what exists on the tapes of sessions provides useful information to the supervisor and therapist. By using the *ACRA Global Procedure Checklist*, a therapist can monitor his or her adherence to the model. A copy of this checklist follows this section.

ACRA Individual Procedure Checklist

ACRA therapists complete individual procedure checklists after each session and after they complete the *ACRA Global Procedure Checklist*. These checklists describe steps specific to each procedure. By completing these checklists, ACRA therapists should improve their compliance over time. The ACRA supervisor should monitor the completion of these checklists and ensure that he or she is in agreement with the therapist. The checklists can also be completed by the ACRA supervisor to provide feedback to the therapist regarding his or her performance during treatment sessions. Copies of procedure checklists follow their appropriate procedure descriptions throughout the manual.

Structure and Process of Supervision

Individual Clinical Supervision

The initial stages of supervision concentrate on establishing an open, honest, approachable, and helpful alliance. Supervision should provide a forum for a therapist to develop and grow. It is very hard for a therapist to do so if he or she is intimidated. A positive approach to supervision is also a form of modeling ACRA treatment. Once a positive working alliance has been established, the process of supervision is much more productive. The ACRA supervisor functions as a teacher, skill developer, resource person, coach, team captain, and motivator. He or she must have skill and knowledge in basic counseling tasks and ACRA procedures and be able to convey that knowledge to others.

Individual supervision should take place at least 1 day per week for 60 to 90 minutes. During this time, numerous activities could occur depending on the needs of the therapist. Typically, this weekly meeting with the therapist begins with a brief overview of his or her cases. The case review is one means of providing the supervisor and therapist with information that can be used to decide how best to use their remaining supervision time for the week. Other information that helps highlight supervision needs includes the supervisor's review of therapy tapes and accompanying checklists. The therapist is also involved in setting the content and agenda for the clinical supervisory sessions to ensure their relevance to his or her needs. The most common focus during a supervision session is discussing the best approaches for addressing clinical issues presented by treatment participants and helping therapists improve their skills in the delivery of ACRA procedures. Typical supervisory activities include reviewing tapes, providing feedback, roleplaying exercises, modeling, providing training or instruction, and problem solving.

Videotape and/or audiotape reviews. Supervisor and therapist reviews of tapes from actual sessions provide important information for supervision. Therapists often initially feel threatened by having their sessions taped, but tapes provide the greatest opportunity for improving their skills. Videotaping also leads to self-supervision; the tape may speak for itself with little need for comments by the supervisor. The therapist has the opportunity to experience feelings and thoughts from the session while listening to the tape, instead of relying on his or her perception of what transpired in the session. The supervisor and therapist can stop a tape frequently to focus on the therapist's behavior and thought processes. Tape reviews provide an opportunity for corrective feedback or for problem solving with the therapist considering what else could have been tried or done at a particular point in the session. The supervisor may choose to model a procedure or ask the therapist to roleplay a procedure so that he or she has the opportunity to improve his or her techniques.

When a supervisor reviews a tape, either alone or with a therapist, it is important to look for a number of behaviors. First, it is important to notice and provide feedback on what the therapist does well. The supervisor can also point out appropriate procedure options within a session that might have been overlooked by the therapist. It is also important that the supervisor review tapes with an eye toward the most common problems found in implementing ACRA treatment. If problems are noticed during the tape review, the supervisor can provide feedback to the therapist and model what the therapist might have said in a given situation. The most common problems in implementing ACRA treatment are listed below.

- Losing sight of an adolescent's reinforcers
- Failing to involve a parent or caregiver in the treatment
- Neglecting to emphasize the importance of having a satisfying social life

- Not stressing the necessity of participating in meaningful activities (school, seeking a general equivalency diploma [GED], work)
- Inadequately monitoring the adolescent's contact with triggers
- Not checking for generalization of skills
- Not using the adolescent's or caregiver's own words as a motivator
- Not determining what motivates the adolescent to change.

Practice roleplays. Intensive and extensive roleplays are excellent skill builders. During supervision, it is important not only to talk about how procedures should be done but also to practice them. Roleplays provide the therapist the opportunity to practice procedures in the safety of a training situation and provide the supervisor the opportunity to give feedback on the therapist's performance. Just like therapy participants, therapists may be embarrassed or reluctant to practice roleplaying. It is important that the supervisor does not convey the expectation of perfection but instead provides support and encouragement. The supervisor can praise the therapist for any efforts he or she made. Because an ACRA supervisor functions as coach and motivator, it is not appropriate to be negative and critical. Because the therapist is expected to use a positive approach with therapy participants, this approach is modeled during supervision as well.

Group Clinical Supervision

If there are multiple therapists providing ACRA treatment, group supervision in addition to individual supervision can be beneficial. Group supervision is efficient because all staff receive the same information at the same time. The group can provide a sense of belonging, group cohesiveness, professional identity, praise, and aid. With individual supervision, there are only two points of view, whereas in group supervision, many ideas are brainstormed and discussed. An optimal approach is a combination of both individual and group sessions for each therapist. The supervision process flows from individual to group, back to individual and so on.

As with individual supervision, a number of activities are appropriate with group supervision, including videotape and/or audiotape reviews, case presentations, peer feedback, peer interaction, and roleplaying. A more structured agenda should be used during group supervision because with multiple therapists involved, it becomes easy to slip into rap sessions or get away from the task at hand. The supervisor needs to regulate the action, amend the course of discussion, and maintain group functions. When a program begins using ACRA procedures, it would be beneficial to have group supervision weekly. As the team becomes cohesive and knowledgeable about the model, these meetings can occur biweekly.

Videotape reviews are an excellent tool for group supervision. Tapes can be stopped at significant junctures for the group to discuss how other

therapists would have handled the situation. Situations encountered by other therapists and viewed on tape provide a stimulus for therapists to share similar clinical problems and provide support and encouragement for one another. However, it is important not to put anyone on the spot. Good judgment and sensitivity should be used to determine whose tape to use in group supervision and when it is appropriate.

Training Resources

For information on training on this approach, contact the following individuals:

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For consultation on this approach, contact:

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Summary

As the process progresses, the ACRA therapist becomes more knowledgeable about and skilled in the delivery of the ACRA procedures. The use of specific techniques usually comes more easily to the therapist than knowing when to use which procedure. Appropriate timing develops along with good judgment and increasing competence. Once a therapist has mastered the techniques, tape reviews are critical to helping the therapist with the timing of procedures. Some of the ongoing tasks of supervision are to train how to conceptualize cases, make treatment decisions, and select the timing of procedures. With tape reviews, rating scales, and checklists, the supervision process provides a method to measure performance and a feedback mechanism to make changes as needed.

Therapist Skillfulness Scale

Supervisor's Name:_____ Therapist Name:_____

ID#:_____ ID#:_____

Subject ID:_____ Session Date:_____ Session Number:_____

Please rate the therapist on the following items:	Not at all	A little	Somewhat	Considerably	Extensively	Not observed	Comments
To what extent did the therapist follow the session format?	1	2	3	4	5		
To what extent did the therapist use language and interventions consistent with the treatment type?	1	2	3	4	5		
To what extent were the treatment goals consistent with the treatment type?	1	2	3	4	5		
To what extent did the therapist demonstrate expertise and competence?	1	2	3	4	5		
To what extent did the therapist engage the client?	1	2	3	4	5		
To what extent did the therapist use interventions at appropriate times (interventions not missed when needed, interventions not made too early)?	1	2	3	4	5		

(Continued on next page)

Please rate the therapist on the following items:	Not at all	A little	Somewhat	Considerably	Extensively	Not observed	Comments
To what extent did the therapist use appropriate self-disclosure?	5	4	3	2	1		
To what extent did the therapist use an appropriate level of activity?	1	2	3	4	5		
To what extent did the therapist maintain the session focus?	1	2	3	4	5		
To what extent did the therapist set an appropriate tone and structure for the session?	1	2	3	4	5		
To what extent did the therapist demonstrate warmth, sensitivity, and genuine concern?	1	2	3	4	5		
To what extent did the therapist understand and express the participant's feelings and concerns?	1	2	3	4	5		

ACRA Global Procedure Checklist

Date _____ Session # _____ Therapist Init. _____ Adolescent ID_____ Supervisor Init._____

Procedures	Used	Could Have Used
1. Rapport building Used open-ended questions		
Praised client for working		
2. Increasing motivation Discussed benefits		
Stated importance of attendance		
Mentioned potential barriers		
3. Functional analysis Completed for substance use		
Completed for prosocial behaviors		
4. Treatment plan Completed *Happiness Scale*		
Completed *Goals of Counseling*		
5. Increasing prosocial recreation Identified interest areas		
Used reinforcer sampling		
Provided systematic encouragement		

(Continued on next page)

Procedures	Used	Could Have Used
6. Relapse prevention Identified early warning system		
Used functional analysis		
Outlined the behavioral chain		
Provided refusal training		
Used cognitive restructuring		
7. Communication skills Assessed quality of communication		
Taught techniques		
Conducted a roleplay		
8. Problem solving Defined problem		
Tried brainstorming		
Chose a solution		
9. Urine testing Recorded results		
Reviewed results		
10. Caregiver overview Used rapport-building techniques		
Provided overview of ACRA procedures		
Looked for caregiver motivators		

(Continued on next page)

Procedures	Used	Could Have Used
Identified most important things from research		
Assessed need for other referrals		
11. Caregiver communication Provided rationale		
Assessed quality of communication		
Roleplayed		
12. Caregiver–adolescent relationship skills Found positive things about each other		
Reviewed communication skills		
Reviewed problem-solving skills		
Completed *Relationship Happiness Scales*		
Gave a reminder to be nice		
Provided closure with caregiver		
13. Dealing with failure to attend Contacted client		
Motivated client		
Rescheduled appointment		
14. Job finding Assessed job categories		
Developed job leads		

(Continued on next page)

Procedures	Used	Could Have Used
Roleplayed asking for applications and interviews		
15. Anger management Identified reinforcers		
Discussed and practiced techniques		
16. Treatment closure Reviewed progress		
Analyzed gains		
Reviewed information		
Reinforced efforts and hard work		
Provided a discharge packet		
17. Odds and ends Looked for reinforcers		
Tied in reinforcers		
Used roleplays		
Assigned homework		
18. Other		

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Appendix. Clinical Management of a Multisite Field Trial of Five Outpatient Treatments for Adolescent Substance Abuse

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Abstract

Bridging the gap between clinical research and clinical practice in the treatment of adolescent substance abuse requires empirically validated therapies and technology transfer strategies that reflect an awareness of the realities and resource constraints of local treatment service providers. This article describes the management of cross-site and cross-intervention clinical issues in the Cannabis Youth Treatment (CYT) study, a multisite, randomized, clinical trial of five outpatient therapies. The methods used in the management of such clinical trials could play an important role in elevating the quality of adolescent substance abuse treatment as practiced in the field. This technology involves 1) defining and delineating clinically relevant subpopulations of clients, 2) developing research-supported manuals that define the theory, active ingredients, and procedures of treatment, 3) monitoring therapist adherence to manual-based therapy, 4) monitoring client responses to the procedures as they are implemented, 5) individualizing and refining the delivery of these manual-based therapies within the context of clinical supervision, and 6) conducting rigorous and sustained followup to determine the enduring effects of the interventions.

Carroll and her colleagues (1994) detailed the strategies used to implement and to protect the integrity of three manual-based therapies evaluated within Project MATCH, a multisite study of adult alcoholism treatment (Project MATCH Research Group, 1993). This paper takes a similar approach in describing cross-site clinical coordination procedures within the Cannabis Youth Treatment study, the largest multisite, randomized field experiment ever conducted of adolescent substance abuse treatment. More specifically, the paper details the common clinical infrastructure within which these therapies were implemented across the treatment sites.

It is our collective experience that therapies can fail in the transition from efficacy (outcomes under ideal circumstances) to effectiveness (outcomes in the real world of adolescent treatment), not because of flaws in the interventions themselves, but because of the absence of a sound foundation of clinical management upon which empirically validated interventions are replicated. The construction of stable clinical infrastructures within local treatment programs is as important to the future of adolescent treatment as the availability of research-validated therapies.

The Cannabis Youth Treatment Study

After declining in the 1980s, both licit and illicit drug use among adolescents rose in the 1990s. In 1996, cannabis use by adolescents (8th, 10th, and 12th graders) reached its highest peak in 12 years for reported lifetime use, past year use, and past month use (ISR, 1997). As cannabis abuse/dependence emerged as the leading cause for admission to substance abuse treatment (OAS, 1997), demands increased for research-validated treatments for cannabis-involved adolescents. In response to this need, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) of the U.S. Department of Health and Human Services (DHHS) funded the CYT study.

The CYT study is a multisite, randomized field experiment designed to test the efficacy of five promising outpatient treatment interventions for cannabis-abusing and cannabis-dependent adolescents. Its long-range goal is to provide validated and cost-effective models of intervention that can be widely replicated in local treatment agencies across the country. The study sites include Chestnut Health Systems in Madison County, Illinois (CHS–MC); the University of Connecticut Health Center (UCHC) in Farmington, Connecticut; Operation PAR in St. Petersburg, Florida (PAR); and the Children's Hospital of Philadelphia (CHOP) in Pennsylvania. The sites represent both academic, research-oriented clinics (UCHC and CHOP) and community-based adolescent treatment programs (CHS–MC and PAR) (Dennis, Babor, Diamond, Donaldson, Goldley, Tims, et al., 1998; Herrell, Babor, Brantley, Dennis, et. al., 1999). The CYT study provides a test in geographically diverse environments of treatments that differ in theoretical orientation, delivery format and focus, and dose.

Between June 1998 and February 1999, 600 adolescents (approximately 150 per site) meeting the criteria presented in the *Diagnostic and Statistical Manual of Mental Disorders* 4th Edition-Revised (DSM–IV) (American Psychiatric Association, 1994) for cannabis abuse or cannabis dependence were randomly assigned to one of three conditions, with a total of five conditions used across the four sites. The five conditions include:

- Motivational Enhancement Therapy/Cognitive Behavioral Therapy—5 individual/group sessions (MET/CBT5) (Sampl & Kadden, 2001)

- Motivational Enhancement Therapy/Cognitive Behavioral Therapy—7 individual/group sessions (MET/CBT5 + CBT7) (Webb, Scudder, Kaminer, & Kadden, in press)

- Family Support Network (FSN) (Hamilton, Brantley, Tims, Angelovich, & McDougall, in press) (FSN includes MET/CBT5 + CBT7 plus enhanced family supports: home visits, parent education classes, parent support groups)

- Adolescent Community Reinforcement Approach (ACRA) (Godley, Meyers, Smith, Karvinen, Titus, Godley, Dent, Passetti, & Kelberg, 2001)

- Multidimensional Family Therapy (MDFT) (Liddle, in press).

At UCHC and PAR, adolescents were assigned to a five-session brief intervention (MET/CBT5) or to one of two other interventions that combine more extensive individual and group sessions (MET/CBT5 + CBT7 or FSN). At CHS–MC and CHOP, adolescents were assigned to the five-session brief intervention (MET/CBT5) or to one of two individual/family approaches (ACRA or MDFT). All study participants were assessed at intake and at 3 months, 6 months, 9 months, and 12 months. Treatment completion rates were in the 70-percent range, and followup rates through 9 months after treatment exceeded 95 percent (Titus et al., 1999; Godley, Diamond, & Liddle, 1999).

Methodological Challenges

There were three important challenges in conducting this multisite field experiment. The first was to ensure the integrity of each of the interventions being tested (Moncher & Prinz, 1991). Following what has been referred to as the "technology model" (Carroll et al., 1994; Carroll & Nuro, 1996; Carroll, 1997), workgroups led by a technical expert in interventions and a therapist coordinator (TC) responsible for cross-site supervision of that intervention took the following six steps to enhance its integrity:

- Defined and manualized the active ingredients of each therapy, including the frequency, intensity, duration, and sequencing, and indicated responses to the most common problems that occur during delivery of the intervention

- Conducted 15 to 25 hours of centralized, competency-based training for the therapists delivering the interventions and followed this by local certification of staff in each intervention

- Developed a therapist's skillfulness scale to serve as a cross-site measure of general therapeutic competence

- Developed a service contact log to measure therapists' adherence to each of the five interventions and to document the dosage and types of services provided to each client

- Taped and rated sessions for model fidelity (all tapes were rated as part of the cross-site supervision by an expert in the intervention until each therapist was certified, after which two tapes per therapist, per month, were reviewed and rated)

- Conducted weekly (1-hour onsite or telephone) individual supervision and weekly or bimonthly (60 to 90 minute) cross-site group supervision for each intervention.

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These procedures helped enhance treatment differentiability (the delineation of the ingredients and procedures that distinguished each treatment from the other treatments) and treatment adherence (the assurance that the interventions [as delivered] maintained fidelity to the original manual-defined procedures) (Hoffart, 1994).

A second challenge involved controlling extraneous factors that could compromise interpretation of the treatment outcomes. To accomplish this, every effort was made to ensure that all general clinical procedures, other than those involved in the specific therapies, would be handled similarly across sites and interventions. This was done to minimize the ability of these contextual issues to unduly influence the evaluation of the experimental interventions and was achieved in two ways. First, staff of the CYT coordinating center conducted two site visits at each of the four service delivery sites to ensure that each site met baseline standards related to arenas such as research protocol compliance, accessibility and appropriateness of clinical space, clinical supervision structure, recruitment strategies, intake and service procedures, confidentiality procedures, crisis and safety net procedures, clinical documentation, data security and storage, and followup procedures. Second, the TCs for each intervention coordinated similar responses to issues that were not part of the specific interventions in monthly conference calls facilitated by the CYT coordinating center. Details of this latter process will be described shortly.

The third challenge was to enhance the external validity of the interventions (the generalizability of study findings) by ensuring that the interventions could be implemented as designed within the resource constraints of settings that currently provide the bulk of services to drug-involved adolescents. It was the goal of the CYT TCs to do everything possible in the CYT study to bridge the traditional gap between efficacy research conducted under experimental (ideal) conditions and effectiveness research conducted in field (real) settings. We wanted to document the kind of clinical infrastructures and the management of day-to-day clinical issues that might need to accompany these unique interventions if they were to achieve comparable results in the field.

The monthly conference calls among the TCs for each of the five interventions and the staff from the CYT coordinating center were particularly helpful in facing the latter two of these challenges. The purpose of these meetings was to define how sites would manage common clinical issues that were not a unique part of the experimental interventions but which, if not identified and controlled, might corrupt the evaluation of these interventions. We were concerned, for example, that if therapists in one intervention expelled adolescents from treatment (and the study) for arriving at a session high, while another site either allowed such adolescents to participate or rescheduled their sessions, differences in completion rates between these sites would reflect not the power or weakness of the interventions but contextual policies unrelated to the active ingredients of each intervention.

What follows is a synopsis of how common clinical issues were managed across the four treatment sites and across the five interventions being

tested. It is hoped that this discussion will provide researchers and treatment practitioners alike with insights into the importance of managing such contextual influences. The discussion also represents a snapshot of baseline clinical practices in adolescent substance abuse treatment in 1998 and 1999.

Issues in Clinical Management and Clinical Care

A. Clinical Infrastructure. A rather complex clinical infrastructure was required to effectively manage clinical activities across the four treatment organizations and the five treatments in the CYT study. The care taken in constructing this infrastructure was based on the assumption that there is a close relationship between the quality of clinical supervision and treatment efficacy (Holloway & Neufeldt, 1995).

There were three levels of clinical coordination and supervision in the CYT study. First, local clinical supervisors at each service site coordinated cross-intervention clinical issues and day-to-day clinical problem solving. Second, a therapist coordinator for each of the five interventions used in the CYT study provided onsite and cross-site clinical supervision of staff working in their particular intervention. This supervision occurred weekly during the period in which therapists were being certified and bimonthly following staff certification. Third, a TC at the CYT coordinating center facilitated cross-site and cross-intervention coordination and problem solving. The centerpiece of this cross-site clinical coordination was a monthly meeting at which the respective TCs met with the cross-site TC and research coordinator via a conference call to discuss cross-site clinical and research issues. Particular problems or procedural questions emerging from these discussions were sometimes also referred to the CYT executive committee (all of the principal investigators, the CSAT project officer, and other CSAT staff) for consultation or decision making. The CYT coordinating center validated that the cross-site clinical procedures developed through these processes were in place by conducting two monitoring visits to each of the CYT research sites during the course of the study (*CYT cooperative agreement,* 1999).

Many problems and issues (administrative, fiscal, research, clinical, ethical, legal) were addressed in this multitiered supervisory structure, but the major goals were to meet the methodological challenges noted earlier: ensuring the integrity of the interventions, controlling factors that could confound outcomes, and enhancing the generalizability of findings. Several steps were taken to achieve these goals.

All sites used the same research and service intake and clinical assessment/screening procedures, the same inclusion and exclusion criteria, and the same approach to randomization and waiting list management. To maximize transferability of findings to the field, exclusion criteria were limited to adolescents 1) who needed a higher level of care than outpatient treatment, 2) who presented for treatment with confirmed histories of drug dealing or violence (particularly predatory behavior patterns reflecting a high frequency, high intensity, and long duration), 3) whose psychiatric comorbidity was so severe as to render them

inappropriate for the CYT interventions, and 4) whose primary drug of choice was not cannabis. Although the study focused on adolescents with a primary drug choice of cannabis, most adolescents entering the CYT study reported using other drugs in addition to cannabis. Although abstinence from all alcohol and drug use was a goal of the treatments in the CYT study, at admission, adolescents were asked to agree to evaluate their drug use and its effects on themselves and their families. Therapists across sites and interventions agreed that many adolescents' commitment to abstinence was something that should emerge out of the treatment process, not something that should be a precondition for entry into treatment.

Mechanisms to enhance clinical fidelity to the interventions used in the study included centralized training and booster training of clinical staff delivering the interventions, the videotaping or audiotaping of all sessions followed by the use of self- and supervisory-scored adherence measures to monitor skillful execution of the intervention, formal procedures to certify each therapist in the intervention, continued postcertification tape reviews to minimize therapist "drift," and regular cross-site group supervision led by an expert in the intervention.

A considerable portion of the monthly meeting of the CYT TCs was aimed at ensuring baseline clinical processes and data collection procedures were being handled consistently across the four sites. There were discussions of just about everything—from drug testing procedures to appropriate responses to clinical deterioration of a study participant. The monthly agenda included a site-by-site review of particular issues, such as the status of therapists' certifications and the quality of communication between sister sites (those delivering the same interventions), and an opportunity to discuss the general problems and issues encountered. Below are some of the cross-site clinical issues that were of major concern throughout the course of the study.

B. Staff Recruitment, Training, and Retention. Most of the therapists working on the CYT project were trained at the master's degree level or higher, and most had prior training and experience in addiction treatment. The research sites, like the practice field, varied in their use of full-time and part-time staff. Most sites felt there were advantages to having full-time therapists working on the project because that increased their availability to clients, provided greater flexibility in scheduling, and created a greater degree of personal investment in the project. In general, sites looked for individuals with good clinical skills whose overall clinical orientations were congruent with the intervention they were going to deliver. A particular effort was made to find staff who had a good working knowledge of child and adolescent development—a qualification not often found in those working with adolescent substance abusers (Kaminer, 1994). Staff were paid salaries that were at or slightly above the geographical norm for addiction therapists. None of the sites experienced any significant problems recruiting qualified staff.

In the course of the project, there were a total of 26 full-time and part-time clinical positions at the four CYT sites. Nine staff left the CYT project

during this period—two due to changes in the communities selected as service sites and the majority of the others due to a return to school, family relocation, or promotion. The highest turnover rate was among the case managers. Several things worked to enhance staff morale and retention on the CYT project: a conscious effort to build team cohesion, a knowledge of the potential importance of the research being conducted, the training and supervision opportunities, the opportunity for cross-site contact with peers working on the same intervention, and the flexibility of the individual sites regarding scheduling of part-time employees on the project.

Although considerable effort is made to ensure that conditions in clinical trials are equivalent to natural conditions in the field, there are several characteristics of clinical trials staff that make them somewhat different from those in mainstream practice. Staff who seek clinical positions in clinical trials are not scared away by the limited timeframe of employment on such a project, are often attracted by the intense nature of training and supervision such projects afford, and are not put off by the rigorous record-keeping generally required in such projects.

Strategies used for managing clinical continuity in the face of staff attrition included replicating the training that was provided to all therapists at the beginning of the CYT project, having a built-in transition/training period for entering staff, and using videotaped sessions of the current therapists to train new therapists.

The safety of staff working in the field was enhanced by hiring staff from the local community, providing inservice training on safety management and access to beepers and cellular phones, and the option of working in teams to visit areas that posed higher safety threats. Office-based safety issues were addressed by ensuring that other staff were present while sessions were being conducted and by providing walkie-talkies or silent alarms to signal other staff if assistance was needed. There were no major safety-related incidents experienced by the CYT project.

C. Client/Family Recruitment, Engagement, and Retention. The major barriers in recruiting, engaging, and retaining adolescents and their families were fairly consistent across the CYT project sites:

- Low adolescent/parent motivation for treatment involvement
- The perception that other problems in the family were more important than the drug experimentation of one child
- Parental substance abuse
- The parental view that smoking marijuana is not that big a deal
- Failure to attend due to lack of transportation or childcare
- A marital or relationship breakup during the period of treatment involvement

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- Inconsistent messages from the parents to the adolescent about the importance of involvement in counseling
- Relocation of the child during the course of treatment
- Parents having given up on efforts to change their child
- A general and pervasive sense of hopelessness about life (felt by both the parents and the adolescent).

Study participants were recruited by direct appeals to youth and parents through newspaper and radio public service announcements and strategically placed bulletin board posters. Staff also oriented local youth service professionals regarding how referrals could be made to the program and the nature of the various treatments that youth would be receiving. These visits and mailings included CYT information packets, business cards, and Rolodex inserts. There was some resistance to referring clients to the project when referral sources discovered that they could not control which intervention their clients would receive. Some were concerned that the five-session intervention would not provide an adequate level of service. After some education about the benefits of brief therapy in general, however, and the need to test such therapies in the substance abuse arena, most were willing to make referrals.

Of 690 adolescents referred to the CYT sites between May 1, 1998, and May 31, 1999, 38.6 percent were referred by criminal justice-affiliated agencies, 24.8 percent by families (7.6 percent of which came from a media promotion of the CYT project), and 15.2 percent by educational community health and human service agencies (Webb & Babor, 1999). An analysis of adolescents admitted to treatment in the CYT study (Tims, Hamilton, Dennis, & Brantley, 1999) revealed that 84.7 percent were age 15 or older, 38.1 percent were nonwhite, and 11.9 percent were female. The low rate of female admissions is attributable to at least two factors. The first involves the use of referral sources such as juvenile probation departments that serve predominantly male clients. The second factor is that, of those females referred to the CYT study, more than one-third presented with comorbid psychiatric disorders severe enough to exclude their participation in the study.

Client engagement was enhanced through five broad strategies. The first was to make the transition between the research staff (the equivalent of the intake staff in most agencies) and the clinical staff as personal as possible. When a therapist was not available to be introduced to the client/family by the research staff, the assigned therapist called the parents or the adolescent before the first appointment to introduce himself or herself, begin alliance building, and clarify any questions about treatment participation. All of the CYT interventions begin with an emphasis on empathy and skillful rapport building to build a strong therapeutic alliance and work through resistance related to the coercive influences that may have brought the adolescent to treatment.

The second strategy was for the therapist to speak for 5 to 10 minutes with any adolescent who had to wait more than 2 weeks to begin service (a delay sometimes caused by randomization and the cycles of starting new groups) to sustain his or her motivation for service involvement.

The third strategy was to remove as many environmental obstacles to treatment participation as possible by using geographically accessible service sites, providing assistance with transportation (that is, cab vouchers, bus tokens, picking adolescents up in the agency van), and providing or arranging childcare. Case management, whether provided by therapists, case managers (in the FSN intervention), or even during the screening activities of the research staff, was an essential medium of engagement for those families whose lives were most chaotic at the point of initial contact with the CYT project. Every effort was made to link what could be learned in treatment with what could help the immediate crisis presented by the family. The CYT interventions shared the message, "We have something that could help with some of these problems and improve the quality of life for you and your child."

The fourth and most important strategy was to actively engage the adolescents and families by creating strong therapeutic alliances, expressing interest in their participation (e.g., by weekly phone prompts for participation), finding a goal that the adolescent and family were interested in working on, expressing optimism in their capacity to change, and persisting in family contacts during the earliest signs of disengagement. FSN intervention staff felt that home visits were very important in initiating and sustaining the involvement of the most treatment-resistant families.

The fifth strategy was to provide a warm, collaborative, adolescent- and parent-friendly environment (with informal but respectful hosting, providing pizza and sodas as part of the dinner-hour adolescent and parent meetings) and to provide specific incentives for involvement in treatment (help with very specific problems, fully subsidized treatment, and token prizes for homework completion).

D. Safety Net Procedures. Safety net procedures involve strategies for recognizing and responding to adolescents who before or after entering outpatient care were thought to be in need of a higher level of care or allied services. We anticipated and experienced four scenarios that required such safety net procedures. The first involved emergency situations that might arise related to an adolescent's drug use during the course of the study. All parents were provided a laminated card listing signs of acute intoxication and oriented to procedures that could be used to respond to an emergency. The second scenario occurred when adolescents underreported the frequency and intensity of their drug use at intake but disclosed it after they were randomized and admitted to one of the therapies. The third scenario involved the frequency and intensity of use escalating after the adolescent had been admitted to outpatient treatment. The fourth scenario occurred when an adolescent's mental health status deteriorated following admission, particularly where such deterioration posed the threat of harm to himself or herself or others. Safety net procedures were established at

all four sites that 1) ensured the periodic reassessment of the status of use and the appropriateness of the level of care to which clients were assigned, 2) ensured the availability and use of supervisory supports to formally reevaluate changes in clients' status and care needs, and 3) facilitated, when needed, moving an adolescent to a more structured and intense level of care or the addition of collateral services. Where alternative or additional services were thought to compromise evaluation of the effect of the CYT intervention, the adolescent and family were provided the additional services but the adolescent was no longer included in the study.

E. Concurrent Services. The exclusion of adolescents with severe psychiatric illness from the CYT study does not mean that all adolescents with psychiatric comorbidity were excluded from the CYT study. The majority of adolescents and families admitted to the CYT study presented with multiple problems, and the rate of psychiatric comorbidity of the adolescents admitted to the study was quite high. Forty-two percent met the criteria for attention deficit/hyperactivity disorder, 55 percent met the criteria for conduct disorder, and 29 percent presented with multiple symptoms of traumatic stress (Tims, Hamilton, Dennis, & Brantley, 1999). Those adolescents who were referred for more intense services prior to randomization and who were not included in the CYT study were most likely to be excluded because they presented a high risk of harm to themselves or others. (These risks were identified through the participant screening form completed at intake and through the assessment instrument [GAIN] [Dennis, Webber, White, et al., 1996] and the interviews that were part of the intake process at all of the CYT service sites.)

The multiple problems presented by the CYT adolescents and their families raised an important clinical and research issue: How to respond to the clinical needs they presented without contaminating (through concurrent service involvement) the evaluation of the particular interventions in the CYT study. This problem was complicated further by the referral patterns of the agencies that linked adolescents with the CYT project. Acutely aware of the number and complexity of the problems many of these adolescents presented, many of these referral sources used a shotgun approach—simultaneously referring the adolescent and family to multiple treatments, hoping that the cumulative dose of services would have some positive effect on the child and family. These problems diminished through education of and negotiation with referral sources. It was a policy of the CYT study that adolescents would not be allowed to remain in the study if they were receiving concurrent treatment whose primary focus was the problem of substance abuse or if they were receiving services whose impact was judged by the local staff to inordinately confound the impact of the CYT intervention being provided. However, no adolescent had to be excluded from the study for such concurrent service involvement. Several adolescents who were treated simultaneously for collateral problems (e.g., being medicated for hyperactivity or depression) were allowed to enter and remain in the CYT study because the focus of the concurrent services was not on substance abuse or dependency.

F. Session Management. Efforts were made to ensure that issues related to the management of sessions that were not unique to the particular interventions would be handled in reasonably consistent ways across the sites. Where procedures were not the same, they were reviewed to ensure the differences would not confound outcomes. These discussions included how to respond to lateness, missed sessions, the criteria for dropping cases, intoxication, contraband, disruptive behavior, preexisting relationships between members, and a group session at which only one member is present.

Lateness was handled by degree, by ensuring either that the client got the minimal dose for that session or that the session was rescheduled. Missed sessions were rescheduled or, in the case of group interventions, provided as an abbreviated makeup session prior to the next scheduled session. (All services across the five modalities were expected to be completed within 14 weeks of the time of the first therapy session, with local TCs reviewing and approving any exceptions to this rule.)

All programs made intoxication and possession of contraband grounds for exclusion from that particular session and a flag for reassessment of the appropriateness of the current level of care. (While rare episodes of an intoxicated youth arriving for services did occur, these episodes were clinically managed without excluding the adolescent from continued service.) Only one adolescent per family was included in the CYT study, and preexisting relationships between participants in the group modalities were reviewed to determine whether the prior history would undermine or enhance treatment. A group with only one member present was conducted in a 30- to 45-minute individual format covering the material that was scheduled for presentation. If an adolescent failed to appear for a family session, the session was conducted without the adolescent.

The TCs collectively sought and implemented general strategies that could enhance the effectiveness of sessions for all of the CYT therapies. Strategies that served to minimize problems and enhance session effectiveness included formalizing, posting, and consistently enforcing group/family norms on such issues as dress (banning drug/gang symbols on clothing) and language (profanity, drug argot). In the group interventions, the closed group structure made it particularly important to guard against negative influences within the peer cultures that evolved. A final issue was the appropriate level of contact between therapists and adolescents outside the intervention. The TCs decided that such contact should be minimized so as not to contaminate model fidelity by altering dose. More specifically, it was agreed that all extra-session contact should be responded to within the therapeutic framework of the particular intervention, channeled into upcoming sessions, documented, and brought to supervisors for review.

G. Gender and Cultural Adaptations. While there is significant momentum toward the development of standardized, empirically supported, and manual-based treatments (Wilson, 1998; Carroll, 1997), there is a simultaneous call for the refinement of standardized treatment that includes gender and cultural relevance and effectiveness (Orlandi, 1995). All of the CYT therapists noted making changes in their delivery of the manual-based treatments

that were based on gender, cultural, and socioeconomic status (SES) appropriateness. Therapists in group interventions explicitly noted diversity issues in the group and incorporated respect for diversity into the ground rules established at the beginning of each group. The most frequently mentioned adaptations included:

- Changing the language of the session to reflect cultural or geographical norms
- Adding items to some worksheets to make them more applicable to urban youth
- Providing special writing and reading assistance to address illiteracy
- Slowing the pace and adding repetitions of key ideas to accommodate learning impairments
- Developing examples and illustrations of key points that had greater gender, cultural, and SES relevance.

Therapists emphasized it was not the content of interventions that had changed; there were subtle changes in the way that content was framed or delivered.

H. Case Mix Issues. Therapists involved in the group interventions (MET/CBT5, MET/CBT5 + CBT7, FSN) also decided to monitor closely client mix issues according to gender, ethnicity, and other important dimensions. There was an effort to identify any potential iatrogenic effects of randomization (e.g., harassment, scapegoating, or other predatory targeting of a vulnerable group member by other group members) and to actively manage potential negative effects of group support for antisocial behavior (Dision, McCord, & Poulin, 1999). This was managed primarily by establishing and enforcing norms for group sessions.

I. Mutual Aid and Peer Support Groups. In contrast to Project MATCH, a 12-step facilitation therapy was not included in the CYT study, and there was some variation in the philosophies of the 5 interventions related to the desirability of mutual aid involvement by cannabis-involved adolescents. The ACRA, MDFT, and MET/CBT interventions do not directly encourage affiliation with addiction recovery support groups, but they do frame such involvement positively if the adolescent is already involved in such a group or self-initiates involvement during the course of treatment. FSN, while strongly encouraging parents to participate in Al-Anon, does not directly encourage adolescent clients to affiliate with Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). Information on local mutual support groups is provided simply as one of many community resources. There was more of an emphasis in all the CYT interventions on involvement in drug-free prosocial activities in general than on addiction recovery support group involvement.

J. Ethical Issues. The TC meetings also provided a venue to discuss and formulate responses to some of the complex ethical and legal issues that can arise in the treatment of adolescent substance abuse (White, 1993). Considerable time was spent discussing questions such as:

- What are the boundaries of confidentiality regarding disclosure of information about an adolescent to his or her parents?
- Do parents have a legal/ethical right to the results of their child's urine tests?
- What circumstances would constitute a duty to report or duty to intervene?
- What obligations, if any, do therapists have in responding to an adolescent's disclosures of past or planned criminal activity?
- How should therapists respond to reports of abuse of adolescents by a parent or to failures by child protection agencies to intervene to ensure the safety of the adolescent?

Discussion

Carroll and colleagues (1994, 1996, 1997) are to be commended for helping transfer the technology model of psychotherapy research to addiction treatment outcome studies. The CYT study greatly benefited from the earlier experience of Project MATCH in the use of this model. This paper has described a structure (the interface between a cross-site and cross-intervention TC group and the CYT executive committee) and a process (monthly meetings of all the TCs and monitoring visits at each CYT study site) that were used to control contextual elements surrounding the experimental interventions. Our goal was to hold these contextual elements constant across the interventions in order to enhance our ability to measure the differences the experimental interventions produced on outcome measures. We wanted differences in outcomes to reflect differences in the interventions themselves and not factors incidental to the interventions.

While there were major research design elements (consistency in clinical data collection instruments and procedures, inclusion and exclusion criteria, and followup procedures) that helped control such variance across sites and interventions, we also sought to identify more subtle areas of potential contamination of the study. By generating consistent cross-intervention procedures to respond to lateness, missed sessions, disruptiveness, intoxication, and concurrent participation in other services, we were able to ensure a consistent and a more precise definition of the dose and type of services provided in, and collateral to, each intervention. By developing and monitoring safety net procedures across the sites and interventions, we were able to ensure timely and appropriate responses to the placement of a client in an inappropriate outpatient modality who needed a higher level of care and to respond to acute episodes of clinical deterioration that warranted a similar change in the level of care. We found

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that the collaborative work of the TCs helped enhance the methodological rigor of the CYT study and helped establish a sound clinical infrastructure upon which each of the interventions was tested.

There are many aspects of the clinical management of the CYT project other than the efficacy of the particular interventions used that may have wide applicability to the field of adolescent substance abuse treatment. It is our view that many of the procedures to provide overall clinical management of randomized field trials have great clinical utility and are likely to become future baseline clinical practices in the treatment of adult and adolescent substance abuse disorders.

The technology model that, to date, has been used primarily as a means of ensuring methodological rigor in multisite field trials seems to us to have enormous advantages for enhancing the quality of treatment and should be studied for potential adaptation to mainstream clinical practice. Those looking for ways to enhance the quality of adolescent substance abuse treatment would be well served to explore how the elements of this model could become part of the future definition of treatment as usual. Parents seeking help to address the substance abuse-related problems of their son or daughter ought to be able to expect that the theory behind the treatments they are offered can be articulated and that their active ingredients can be defined. They should further be able to expect that these treatments have some degree of scientific support for their effectiveness and that they will be delivered in a manner consistent with procedures whose effectiveness has been validated.

Increased demands for such accountability and fidelity by parents, policy makers, and funding agencies will likely make manual-based therapies the rule in the future, along with the training and adherence measures that accompany them. The technical aspects of cross-site clinical management of the CYT project have much to offer the field as a whole. The use of standardized assessment instruments that are capable of providing comprehensive assessment and treatment planning data should become a requirement of all adolescent treatment programs in the next decade. We further commend the use of central (and booster) training, videotaping and adherence ratings as standard practices in supervision, and cross-site supervision as marvelous tools for training and professional development. Finally, we believe that rigorous followup (monitoring, feedback, and, where indicated, early reintervention) should move from the realm of clinical research to being an expectation, if not a requirement, of mainstream clinical practice. The idea of providing services without measuring outcomes will be incomprehensible in the very near future, and the technology to perform this task is rapidly emerging. Morale among staff working in the CYT project remained high, in part because of the near universal belief in the historical importance of this study and the climate of excitement and discovery that permeated the project. We believe that small field-based experiments to answer critical clinical questions, opportunities for cross-site sharing, and the opportunity to work on papers and presentations can similarly contribute to staff morale within local service organizations. We believe this milieu of curiosity, discovery, and contribution is transferable and sustainable in

natural clinical settings. Routine outcome monitoring and field-based experiments, like the other items in this discussion, must simply be moved from the arena of clinical research to the arena of standard clinical practice. This transfer of technology from the research environment to the clinical practice environment, however, will not be simple.

If there is a single weak link in the current practice of addiction treatment that will slow this technology transfer, we believe it is in the arena of clinical supervision. Comprehensive assessments, science-guided treatment planning, empirically validated and manual-based therapies, regular adherence measurement and monitoring, using clients' response-to-treatment data to individualize and refine standard interventions, and rigorous posttreatment followup (and early reintervention, where called for) all flow from the clinical infrastructure at the core of which is a clinical supervisor. If we can elevate the quality of clinical supervision in the field—the selection, training, and support of clinical supervisors to do true clinical supervision—to that of clinical supervision in controlled clinical trials, we will be able to channel knowledge from clinical research to clinical practice.

Conclusions

Clearly defining the demographic and clinical characteristics of client populations, presenting the active ingredients in a manual format and procedures inherent in particular treatments for those populations, monitoring therapists' adherence to such procedures, controlling contextual influences that can influence treatment outcomes, and conducting rigorous and sustained followup to determine clients' responses to particular interventions collectively hold great promise in moving the treatment of adolescent substance abuse from the status of a folk art to that of a clinical science. The technologies used to build this science may themselves offer great potential in enhancing the quality of adolescent substance abuse treatment programs if they can be adapted for routine use in the clinical setting. The CYT study confirms the importance that these new tools can and will have in the future clinical management of adolescent substance abuse treatment.

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